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Source Book of Health Insurance Data 1982-1983

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Foreword

The 1982-83 edition of the *Source Book of Health Insurance Data* is a statistical report of the private health insurance business in the United States. It is published by the Public Relations Division of the Health Insurance Association of America on behalf of companies that provide health insurance to the American public.

This 24rd edition of the *Source Book* provides the latest available data on major forms of health insurance: hospital, surgical, physician's expense, major medical, disability and dental insurance. Also included is information on medical care costs, morbidity and health manpower in the United States. The data have been compiled from reports of insurance companies and other health insurance plans, government agencies and hospital and medical associations.

The *Source Book* is used as a reference by writers, editors, researchers, educators, government leaders, hospital and medical professionals, business associations and unions, and others interested in health care and its financing.

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Key Health Insurance Statistics

	1976	1980	1981	% Change 1980-81	% Change 1976-81
Number of Persons with Private Health Insurance Protection in the United States (000 Omitted)					
Hospital expense	176,581	189,000	188,340	- .3	6.7
Surgical expense	167,432	178,223	176,898	- .7	5.7
Physician's expense	163,094	169,529	163,944	- 3.3	.5
Major medical expense	134,992	155,192	157,702	1.6	16.8
Disability income:					
Short-term	62,250	65,400	60,306	- 7.8	- 3.1
Long-term	17,779	21,093	21,682	2.8	22.0
Dental expense	41,559	80,528*	86,302*	7.2	107.7
Health Insurance Benefit Payments in the United States (000,000 Omitted)					
Insurance companies	$20,217	$37,002	$41,622	12.5	105.9
Blue Cross-Blue Shield and other plans	20,020	37,086	42,477	14.5	112.2
Total†	$37,966	$67,087	$75,888	13.1	99.9
Health Insurance Premiums in the United States (000,000 Omitted)**					
Insurance companies	$24,502	$43,666	$48,998	12.2	100.0
Blue Cross-Blue Shield and other plans	21,455	38,630	45,229*	17.1	110.8
Total†	$43,468	$74,669	$84,883	13.7	95.3
Community Hospital Statistics in the United States					
Average length of hospital stay (days)	7.7	7.6	7.6	-	-1.3
Average cost to hospital per patient day	$151.80	$245.10	$284.30	16.0	87.3
Average cost to hospital per patient stay	$1,168.90	$1,862.80	$2,160.70	16.0	84.8

*Estimate.

**Data for "Insurance companies" refer to earned premiums. Data for "Blue Cross-Blue Shield and other plans" refer to earned income.

†"Total" Benefits and Premiums eliminate the estimated duplication that results from insurance companies and the Health Care Financing Administration ("Other Plans" data) both reporting Administrative Services Only benefits in their data.

NOTE: Some data are revised from previous years.

SOURCES: Health Insurance Association of America, Blue Cross Association, Blue Shield Association, American Hospital Association and U.S. Department of Health and Human Services.

CHAPTER 1
Extent of Private Health Insurance Coverage

At the end of 1981, more than 188 million Americans — 84% of the civilian noninstitutional population — were protected by one or more forms of private health insurance (Table 1.1).

These included nearly 173 million persons under 65 — representing 86% of this age group. Nearly 16 million older persons — 5 of 6 in the 65-and-older population — held private health insurance policies to supplement benefits available through Medicare.

Various forms of private health insurance coverage are available from several different types of insurers: insurance companies, hospital and medical service plans like Blue Cross and Blue Shield, group medical plans operating on a prepayment basis such as health maintenance organizations, and others.

Over 1,000 private insurance companies in the United States were writing individual and/or group health insurance covering over 108 million persons at year-end 1981. Policies issued by insurance companies provide for payment directly to the insured or, if assigned by the insured, to the provider of services for reimbursement of expenses incurred. Health insurance coverage made available by insurance companies can be divided into two basic categories — *medical expense* insurance and *disability income* insurance. *Medical expense* insurance is a "reimbursement type" of coverage which provides broad benefits that can cover virtually all expenses connected with hospital and medical care and related services. *Disability income* insurance provides periodic payments when the insured is unable to work as a result of sickness or injury.

The Blue Cross and Blue Shield Association coordinates the Blue Cross and Blue Shield plans of the nation. The nonprofit member plans service statewide and other geographical areas, offering both individual and group coverage.

Blue Cross plans provide hospital care benefits on essentially a "service type" basis, under which the organization, through a separate contract with member hospitals, reimburses the hospital for covered services provided to the insured.

Blue Shield plans provide benefits for surgical and medical services performed by a physician. The typical Blue Shield plan provides benefits similar to those provided under the benefit provisions of hospital-surgical policies issued by insurance companies. In 1982, there were 68 Blue Cross plans and 69 Blue Shield plans in the United States. Some of these were joint plans, making a total of 103 Blue Cross and Blue Shield plans.

Health care coverage is also provided through health maintenance organizations (HMOs), which provide comprehensive health care services for their members for a fixed periodic payment. In such plans a group of physicians, surgeons, dentists or optometrists furnish needed care as specified in the contract to subscribers. From 1972 to 1982, the number

of operational HMOs increased from 39 to 277 and the number of subscribers increased from 3.5 million to 10.8 million.

Certain types of health insurance coverage are also made available by plans that are administered by employers or labor unions, fraternal societies, communities, or by rural and consumer health cooperatives. Usually the protection provided by these groups is the amount desired and affordable by a specific group of people.

It is estimated that some 30% of the total 1981 insurance company group coverage is represented by Administrative Service Only (ASO) arrangements and Minimum Premium Plans (MPPs). Under these systems, corporations and other organizations establish self-funded health plans. Insurance carriers or private organizations are paid a fee by the self-funding group to process the claims and benefits paperwork. Under MPPs, many employers also insure against a certain level of large, unpredictable claims. These types of arrangements represented approximately 25% of total insurance company group coverage in 1980 and less than 5% prior to 1975.

Hospital Expense Insurance

At the end of 1981, 188 million persons were covered for hospital expenses by private health insurance (Table 1.2), the most common type of medical expense coverage. This coverage has grown 16% since 1971.

Hospital expense coverage provides specific benefits for daily hospital room and board and usual hospital services and supplies during hospital confinement. Room and board benefits are usually stated in one of two ways: one is reimbursement for the actual room and board charge up to a specified maximum amount per day for hospital confinement. The second provides a service-type benefit that equals the semiprivate room and board charge of the hospital.

Hospital expense benefits are provided in one of three ways: by a hospital expense insurance policy that is often sold in combination with a surgical expense insurance policy so as to also provide benefits for both surgical operations and doctors' in-hospital visits; by major medical policies that provide broad and substantial coverage for many types of medical expenses; and by hospital indemnity policies.

Hospital indemnity coverage is issued to individuals and provides a stipulated daily, weekly or monthly indemnity during hospital confinement. The money is payable without regard to the actual expense of hospital confinement or the existence of other insurance coverage.

A study by the Health Insurance Association of America examined the extent of health insurance coverage among 21.8 million employees covered under group policies at year-end 1980. The results, published in *A Profile of Group Medical Expense Insurance*, show that among the employees with hospital expense coverage, 99% had hospital coverage at a level of 80% or more of the average semiprivate room and board rate in the employee's local area.

At year-end 1981, 15.6 million persons over age 65 were covered by private health insurance, including 7.2

million protected by hospital coverage issued through insurance companies. This latter figure included 3.1 million with hospital indemnity coverage and 4.1 million with supplemental coverage for Medicare Part A. At the same time, 2.7 million persons over age 65 had coverage through insurance companies to supplement Medicare Part B (surgical/medical).

The table below shows the number of persons aged 65 and over with various types of coverage.

Hospital Indemnity	3,078,000
Medicare Part A — hospital copayment coverage	4,097,000
	7,175,000
Medicare Part B — surgical copayment coverage	2,655,000
Prescribed Drugs and Medicines	1,319,000
Nursing Home Care	2,177,000
Private Duty Nurse	1,559,000

Surgical Expense Insurance

At the end of 1981, 177 million persons had protection against the costs of surgery (Table 1.3), a 16% growth since 1971.

This coverage provides benefits for the cost of surgical procedures performed as a result of an accident or sickness. Payment toward charges for administration of an anesthetic for a covered surgical procedure is often included. Benefits under this form of insurance might be paid according to a schedule of surgical procedures, with the policy listing the maximum benefit for each type of operation covered. An increasing number of insurance plans offer surgical benefits for the physician's fee up to the "reasonable and customary" charge for the procedure performed. No separate surgical schedules are included in this type of policy.

The 1980 HIAA *Profile of Group Medical Expense Insurance* showed that 99% of employees were covered under policies that provided surgical expense benefits at a level of 80% or more of the prevailing reasonable and customary charge.

Physician's Expense Insurance

At year-end 1981, 164 million persons (Table 1.4) had physician's expense coverage (formerly termed regular medical expense insurance). This form of health insurance provides benefits to help pay a physician's fees for nonsurgical care in a hospital, home or doctor's office. There are usually maximum benefits for specific services that sometimes include diagnostic X-ray and laboratory expenses.

Major Medical Expense Insurance

Major medical expense insurance — introduced nationally by insurance companies in 1951 — has grown rapidly. By the end of 1981, some 158 million persons had major medical coverage through insurance company policies, Blue Cross-Blue Shield, HMOs and other independent plans (Table 1.5). Insurance companies alone covered over 107 million persons (Table 1.6).

Major medical coverage provides broad and substantial protection for large, unpredictable medical expenses. It covers a wide range of medical

charges with few internal limits and a high overall maximum benefit. Basically, there are two types of major medical plans: one supplements basic hospital-surgical-physician's expense insurance programs; the other provides comprehensive protection where both basic coverage and extended health care benefits are integrated.

Maximum benefits range from $10,000 per person to, in some cases, unlimited benefits. Nearly 90% of the 21.8 million employees in the 1980 HIAA *Profile* study were covered under a major medical expense policy. Some 73% of these had a maximum benefit of $250,000 or more; 46% had a maximum benefit of $1 million or an unlimited amount; and 89% had a maximum of $50,000 or more. In 1970, only 15% of employees with major medical expense coverage had a maximum benefit of $50,000 or more. Two-thirds of the employees had an annual out-of-pocket limit of $1,000 or less. The most common deductible was $100.

A survey of new group major medical benefits revealed that of those plans issued by insurance companies in 1982, 88% of surveyed employees had maximum benefits of more than $100,000. Of those with maximum benefits of more than $100,000, 48% had maximums of $1 million and over, and 33% had unlimited benefits.

Generally, insurance company and medical plan benefits are subject to some form of deductible and coinsurance payments by the insured.

Disability Income Protection

Disability income benefits provide for the partial replacement of income lost by employees as the result of an accident, illness or pregnancy. Generally, disability income policies are divided into two types—those that provide benefits for up to two years (short-term) and those that provide benefits for a longer period, usually for at least 5 years but often to age 65 or for life (long-term).

The amount of the benefit may vary depending upon whether disability is total or partial, and the duration of benefits may vary depending on whether the disability is the result of an accident or an illness. Some policies include a provision whereby monthly income benefits are increased each year according to a predetermined formula which may be related to the cost of living.

When provided on a group basis, the benefits are usually integrated with benefits from Social Security and other public programs. The total level of benefits from these sources is generally set at a level that does not exceed 60% of salary.

Individual disability income policies usually provide a fixed dollar amount of coverage. This amount may be greater for those who are turned down by Social Security. Individual disability income policies take many forms, designed to fit the special needs of the individual policyowner.

Such policies include Return of Premium, Key Person, Overhead Expense, and Buy-Sell Policies. Other types of coverage that may include disability income benefits are travel accident, automobile (including no-fault), accidental death and dismemberment and hospital indemnity insurance.

At the end of 1981, 80 million persons had some form of disability income coverage. This amounts to 80%

of the civilian labor force. Some 60 million persons in the United States were covered by short-term protection through insurance company plans or other formal arrangements, and almost 22 million persons were covered by long-term policies of insurance companies. More than 2 million persons covered by long-term plans also had short-term coverage. The apparent drop in short-term disability income coverage from 1978 through 1981 reported in Table 1.7 is because of the increase in the number of employers choosing Administrative Service Only arrangements or Minimum Premium Plans over fully-insured coverage. Such arrangements are not included in the data reported in Table 1.7.

Dental Expense Insurance

Dental expense insurance provides reimbursement for expenses of dental services and supplies and encourages preventive care. The coverage normally provides for oral examinations (including X-rays and cleanings), fillings, extractions, inlays, bridgework and dentures, as well as oral surgery, root canal therapy and orthodontics.

Dental coverage is generally available through insurance company group plans, prepayment plans and dental service corporations.

It is estimated that 86 million persons were protected by some form of dental expense insurance at year-end 1981 (Table 1.8). This included nearly 23 million persons with coverage under more than one policy or by more than one insuring organization.

The largest providers of this type of protection are insurance companies, which insured 61 million persons through group policies at the end of 1981, compared to 27 million in 1976.

Blue Cross-Blue Shield plans, which first offered dental coverage in the late 1960s, covered 12 million persons at the end of 1981. An additional 36 million persons were covered by dental service corporations, HMOs or through union self-insurance trusts in which union welfare funds directly reimburse dentists in group practice clinics.

The 1980 HIAA *Profile* study found that 46% of employees in the survey had coverage for dental care expenses. Of these, 60% were covered for orthodontia expenses.

The Uninsured Population

Estimates of the number of persons in the United States without private or public protection against health care expenses have been developed by private and governmental agencies.

The purpose of this section is to summarize various studies. No attempt has been made to analyze the accuracy of the findings due to differences in definitions, methodology and time periods covered.

The Social Security Administration estimates that in 1976, some 24 to 25 million persons (12% to 13% of the U.S. population under age 65) had no public or private protection against the cost of hospital or surgical care.[1]

A study conducted by The Robert Wood Johnson Foundation concurs with the Social Security Administration's estimate.[2]

Based on estimates from 1974 and 1975, a study conducted by Pracon, Inc., for LaRoche Laboratories concludes that only 6% of the total population, some 12.2 million persons, have no private or public health

insurance coverage.[3]

A study conducted during the first four months of 1977 by the National Center for Health Services Research concludes that 24.1 million persons, had no health insurance at that time.[4]

The Congressional Budget Office's most recent report on the uninsured population concludes that from 11 to 18 million persons (some 5% to 8% of the population) were without health care coverage in 1978. According to its findings, young adults are almost twice as likely as any other age group to be without coverage and, although they account for only 11% of the population, they represent over 20% of the uncovered population. Among employed persons, those earning less than $10,000 are most likely to be without coverage, accounting for 55% of the unprotected population.[5]

A 1978 survey by the National Center for Health Statistics concluded that 21.3 million persons (10% of the population) had no private or public health insurance coverage.[6]

1. Social Security Administration, Social Security Bulletin, September 1978, Vol. 41, No. 9, *Private Health Insurance Plans in 1976: An Evaluation.*
2. The Robert Wood Johnson Foundation, *Special Report Number One: A New Survey on Access to Medical Care*, 1978.
3. Hoffmann-LaRoche Inc., *National Health Insurance Issues — The Unprotected Population*, 1977.
4. National Center for Health Services Research, U.S. Department of Health and Human Services. *The Uninsured and Their Use of Health Services*, 1981.
5. U.S. Congressional Budget Office, *Profile of Health Care Coverage: The Haves and Have-Nots*, 1979.
6. National Center for Health Statistics, U.S. Department of Health and Human Services. *Health Care Coverage Under Private Health Insurance, Medicare, Medicaid, and Military or Veterans Administration Health Benefits:* United States, 1978.

Table 1.1
Number of Persons with Health Insurance Protection by Type of Coverage in the United States
(000 omitted)

End of year	Hospital expense	Surgical expense	Physician's expense	Major medical expense	Disability income		Dental expense
					Short-term	Long-term	
1940	11,962	4,900	3,000	–	N.A.	N.A.	–
1945	32,072	12,602	4,713	–	N.A.	N.A.	–
1950	76,639	54,156	21,589	–	37,793	*	–
1955	101,400	85,681	53,038	N.A.	39,513	*	–
1960	122,500	111,525	83,172	32,590	42,436	*	N.A.
1961	125,825	116,376	90,393	41,974	43,055	*	N.A.
1962	129,407	119,766	94,717	48,393	45,002	*	N.A.
1963	133,472	124,105	100,095	55,382	44,246	3,029	N.A.
1964	136,304	127,092	106,007	62,112	45,092	3,363	N.A.
1965	138,671	130,530	109,560	69,666	46,927	4,514	N.A.
1966	142,369	133,995	113,986	73,843	49,931	5,068	N.A.
1967	146,409	138,898	119,913	81,550	51,975	6,778	4,570
1968	151,947	143,625	126,233	87,641	55,636	7,836	5,867
1969	155,025	147,774	131,792	95,528	57,770	9,282	8,858
1970	158,847	151,440	138,658	103,544	58,089	10,966	11,972
1971	161,849	153,093	139,399	108,813	59,280	12,284	15,263
1972	164,098	154,687	140,873	113,837	61,548	14,538	16,853
1973	168,455	162,644	151,680	124,627	64,168	17,011	20,418
1974	173,140	166,434	158,170	131,438	65,282	17,799	27,855
1975	177,980	168,895	161,854	134,092	62,971	18,396	30,246
1976	176,581	167,432	163,094	134,992	62,250	17,779	41,559
1977	178,968	167,220	160,429	139,362	64,627	19,364	50,301
1978	184,740	173,324	164,970	141,538	68,307	19,100	58,059†
1979	184,121	174,686	164,754	147,555	65,808	19,920	70,171†
1980	189,000	178,223	169,529	155,192	65,400	21,093	80,528†
1981:							
Under 65	172,726	165,638	153,319	154,513	N.A.	21,682	N.A.
65 and over	15,614	11,260	10,625	3,189	N.A.	–	N.A.
Total	188,340	176,898	163,944	157,702	60,306	21,682	86,302†

N.A. - Not available.

*Included in "Short-term," with the possibility of some duplication of disability income coverage for these years.

†Estimate.

NOTE: Some data are revised from previous years. For 1975 and later, data include the number of persons covered in Puerto Rico and other U.S. territories and possessions. The data refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

SOURCES: Health Insurance Association of America, Blue Cross Association, Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.2
Number of Persons with Hospital Insurance Protection by Type of Insurer in the United States

(000 omitted)

End of year	All insurers*	Insurance Companies			Blue Cross/ Blue Shield	Other plans
		All insurance companies*	Group policies	Individual and family policies		
1940	11,962	3,700	2,500	1,200	6,012	2,250
1945	32,072	10,504	7,804	2,700	18,899	2,670
1950	76,639	36,955	22,305	17,296	38,822	4,445
1955	101,400	53,480	38,620	19,887	50,726	6,545
1960	122,500	69,226	54,416	22,181	58,050	5,994
1961	125,825	70,367	56,077	22,420	58,664	7,102
1962	129,407	72,156	58,057	23,035	60,118	6,937
1963	133,472	74,478	61,448	23,516	61,016	7,165
1964	136,304	75,825	63,011	23,951	62,054	6,840
1965	138,671	77,642	65,415	24,424	63,347	6,984
1966	142,369	80,419	67,799	24,888	65,310	6,633
1967	146,409	82,603	71,454	24,619	67,214	7,050
1968	151,947	85,705	74,073	25,278	70,019	7,277
1969	155,025	88,798	77,973	25,922	72,692	7,702
1970	158,847	89,688	80,505	26,658	75,055	8,131
1971	161,849	91,531	80,641	27,773	76,539	8,545
1972	164,098	93,681	81,526	29,011	78,206	8,053
1973	168,455	94,544	83,626	27,544	81,345	9,562
1974	173,140	97,010	85,385	28,807	83,845	11,072
1975	177,980	99,547	87,185	30,115	86,436	12,581
1976	176,581	97,038	86,824	26,996	86,601	14,091
1977	178,968	100,378	89,219	28,687	86,024	15,600
1978	184,740	106,480	93,164	36,226	85,816	17,271†
1979	184,121	105,263	95,194	34,612	86,148	19,121†
1980	189,000	107,313	99,108	34,097	86,721	33,152†
1981:						
Under 65	172,726	101,197	101,408	20,414	76,343†	35,932†
65 and over	15,614	7,175	3,991	5,178	9,430†	4,373†
Total	188,340	108,372	105,399	25,592	85,773†	40,305†

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

†Estimate.

NOTE: Some data are revised from previous years. For 1975 and later, data include the number of persons covered in Puerto Rico and other U.S. territories and possessions. Persons covered under insurance company Administrative Service Only agreements and Minimum Premium Plans are included in the categories "All insurance companies" and "Group policies."

SOURCES: Health Insurance Association of America, Blue Cross Association, Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.3
Number of Persons with Surgical Expense Protection by Type of Insurer in the United States
(000 omitted)

End of year	All insurers*	Insurance Companies			Blue Cross/ Blue Shield	Other plans
		All insurance companies*	Group policies	Individual and family policies		
1940	4,900	2,280	1,430	850	370	2,250
1945	12,602	7,337	5,537	1,800	2,845	2,420
1950	54,156	33,428	21,219	13,718	19,690	3,760
1955	85,681	50,146	39,703	14,972	39,165	5,930
1960	111,525	65,093	55,464	16,025	50,281	7,336
1961	116,376	67,103	57,017	16,533	50,166	8,494
1962	119,766	68,814	59,025	16,706	51,342	8,287
1963	124,105	71,580	61,937	17,113	51,845	8,608
1964	127,092	72,802	63,310	17,259	52,953	8,297
1965	130,530	75,186	65,487	17,735	53,945	8,684
1966	133,995	77,434	68,114	17,751	55,968	8,325
1967	138,898	80,090	72,038	17,603	58,248	8,580
1968	143,625	82,088	75,038	17,471	61,336	8,752
1969	147,774	84,850	78,864	17,699	63,926	9,950
1970	151,440	85,661	81,549	17,961	66,042	10,532
1971	153,093	86,254	81,802	18,134	67,203	10,860
1972	154,687	87,395	82,670	18,560	69,072	10,273
1973	162,644	89,061	84,483	18,608	75,136	11,994
1974	166,434	90,879	86,561	18,534	76,873	13,714
1975	168,895	92,089	87,958	18,468	77,803	15,435
1976	167,432	90,744	88,327	16,072	76,943	17,155
1977	167,220	92,799	91,904	14,409	74,523	18,876
1978	173,324	97,112	95,585	16,917	74,604	20,770†
1979	174,686	99,614	97,623	17,930	74,522	22,854†
1980	178,223	100,999	100,559	17,558	73,626	36,885†
1981:						
Under 65	165,638	99,369	103,600	11,023	63,315†	41,332†
65 and over	11,260	2,655	1,881	1,402	8,456†	3,511†
Total	176,898	102,024	105,481	12,425	71,771†	44,843†

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

†Estimate.

NOTE: Some data are revised from previous years. For 1975 and later, data include the number of persons covered in Puerto Rico and other U.S. territories and possessions. Persons covered under insurance company Administrative Service Only agreements and Minimum Premium Plans are included in the categories "All insurance companies" and "Group policies."

SOURCES: Health Insurance Association of America, Blue Cross Association, Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.4
Number of Persons with Physician's Expense Protection by Type of Insurer in the United States

(000 omitted)

End of year	All insurers*	Insurance Companies			Blue Cross/ Blue Shield	Other plans
		All insurance companies*	Group policies	Individual and family policies		
1940	3,000	–	–	–	200	2,800
1945	4,713	535	335	200	1,300	2,878
1950	21,589	8,001	5,587	2,714	11,428	2,873
1955	53,038	22,837	20,537	4,230	29,451	4,639
1960	83,172	37,442	35,522	5,487	45,017	6,773
1961	90,393	40,686	38,154	6,486	45,947	8,583
1962	94,717	43,457	40,557	7,203	47,456	8,343
1963	100,095	47,510	44,541	7,832	48,414	8,647
1964	106,007	52,048	49,447	8,141	49,559	8,850
1965	109,560	55,453	53,258	8,258	50,586	8,718
1966	113,986	59,004	56,851	8,549	52,238	8,434
1967	119,913	62,606	61,028	8,541	54,673	8,680
1968	126,233	66,235	64,566	8,984	57,520	8,900
1969	131,792	69,960	68,872	9,384	59,118	N.A.
1970	138,658	74,888	74,899	10,283	62,273	N.A.
1971	139,399	74,674	75,135	9,936	63,030	N.A.
1972	140,873	75,818	75,920	10,700	64,776	9,462
1973	151,680	79,774	79,862	11,285	71,766	11,222
1974	158,170	82,986	83,642	11,013	74,847	12,982
1975	161,854	86,567	87,027	11,775	74,869	14,741
1976	163,094	87,967	88,886	11,384	74,675	16,501
1977	160,429	88,818	90,159	10,964	71,261	18,261
1978	164,970	91,846	91,684	14,217	70,517	20,350†
1979	164,754	93,158	91,868	15,966	70,439	22,110†
1980	169,529	95,728	95,802	15,962	69,896	32,634†
1981:						
Under 65	153,319	91,292	95,428	9,786	60,108†	40,092†
65 and over	10,625	2,655	1,881	1,402	8,028†	3,230†
Total	163,944	93,947	97,309	11,188	68,136†	43,322†

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

†Estimate.

NOTE: Some data are revised from previous years. For 1975 and later, data include the number of persons covered in Puerto Rico and other U.S. territories and possessions. Persons covered under insurance company Administrative Service Only agreements and Minimum Premium Plans are included in the categories "All insurance companies" and "Group policies."

SOURCES: Health Insurance Association of America, Blue Cross Association, Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.5
Number of Persons with Major Medical Expense Protection by Type of Insurer in the United States
(000 omitted)

End of year	All insurers*	Insurance Companies			Blue Cross/ Blue Shield	Other** plans
		All insurance companies*	Group policies	Individual and family policies		
1951	N.A.	108	96	12	N.A.	N.A.
1955	N.A.	5,241	4,759	482	N.A.	N.A.
1960	32,590	25,371	26,454	1,607	3,713	N.A.
1961	41,974	32,334	34,339	2,372	5,059	N.A.
1962	48,393	37,130	39,081	2,949	7,501	N.A.
1963	55,382	42,003	44,006	3,459	10,000	N.A.
1964	62,112	47,338	49,166	4,185	12,500	N.A.
1965	69,666	53,020	55,412	4,456	14,600	N.A.
1966	73,843	57,881	60,984	4,516	14,352	N.A.
1967	81,550	63,428	67,394	4,552	16,279	N.A.
1968	87,641	68,171	72,436	4,873	17,807	N.A.
1969	95,528	73,752	78,165	5,377	20,328	N.A.
1970	103,544	77,061	81,962	5,414	24,905	N.A.
1971	108,813	80,252	85,553	5,479	26,780	N.A.
1972	113,837	83,668	87,806	6,630	30,082	N.A.
1973	124,627	87,839	91,915	7,310	37,328	N.A.
1974	131,438	91,044	95,532	7,235	40,862	N.A.
1975	134,092	92,166	96,718	7,315	42,058	N.A.
1976	134,992	93,191	98,355	6,672	41,670	N.A.
1977	139,362	96,003	101,925	6,101	39,390	12,419
1978	141,538	102,471	108,872	6,890	39,317	13,707†
1979	147,555	104,493	110,809	7,313	43,341	15,129†
1980	154,223	107,218	115,003	7,470	45,000	25,698†
1981:						
Under 65	154,513	106,116	114,524	6,446	47,391†	31,175†
65 and over	3,189	1,319	1,334	187	1,000†	2,542†
Total	157,702	107,435	115,858	6,633	48,391†	33,717†

N.A. — Not available.

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

**Data prior to 1977 are being revised by the U.S. Department of Health and Human Services. These revisions will not affect the net total of people protected by all insuring organizations.

†Estimate.

NOTE: For 1975 and later, data include the number of persons covered in Puerto Rico and other U.S. territories and possessions. Persons covered under insurance company Administrative Service Only agreements and Minimum Premium Plans are included in the categories "All insurance companies" and "Group policies."

SOURCES: Health Insurance Association of America, Blue Cross Association, Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.6
Number of Persons with Major Medical Expense Protection with Insurance Companies by Type of Policy in the United States
(000 omitted)

End of Year	Insurance company total*	Group policies			Individual and family policies
		Net total*	Supplementary	Comprehensive	
1951	108	96	96	–	12
1955	5,241	4,759	3,928	831	482
1960	25,371	24,429	17,991	8,463	1,607
1961	32,334	30,729	24,488	9,851	2,372
1962	37,130	35,002	28,445	10,636	2,949
1963	42,003	39,446	32,307	11,699	3,459
1964	47,338	44,087	36,925	12,241	4,185
1965	53,020	49,700	42,450	12,962	4,456
1966	57,881	54,732	46,830	14,154	4,516
1967	63,428	60,517	51,824	15,570	4,552
1968	68,171	65,076	55,422	17,014	4,873
1969	73,752	70,272	58,905	19,260	5,377
1970	77,061	73,702	61,718	20,244	5,414
1971	80,252	76,971	63,442	22,111	5,479
1972	83,668	79,025	64,443	23,363	6,630
1973	87,839	82,724	66,225	25,690	7,310
1974	91,044	85,979	67,911	27,621	7,235
1975	92,166	87,046	67,310	29,408	7,315
1976	93,191	88,520	66,753	31,602	6,672
1977	96,003	91,733	68,349	33,576	6,101
1978	102,471	98,073	N.A.	N.A.	6,890
1979	104,493	99,821	N.A.	N.A.	7,313
1980	107,218	102,503	N.A.	N.A.	7,470
1981:					
Under 65	106,116	101,927	69,913	44,611	6,446
65 and over	1,319	1,334	N.A.	N.A.	187
Total	107,435	103,261	N.A.	N.A.	6,633

N.A. — Not available.

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one insurance company policy providing the same type of coverage has been eliminated.

NOTE: For 1975 and later, data include the number of persons covered in Puerto Rico and other U.S. territories and possessions. Persons covered under insurance company Administrative Service Only agreements and Minimum Premium Plans are included in the categories "All insurance companies" and "Group policies."

SOURCE: Health Insurance Association of America.

Table 1.7
Number of Persons with Disability Income Protection by Type of Program in the United States

(000 omitted)

End of year	All programs	Insurance Companies			Formal paid sick leave plans	Other
		All insurance companies	Group policies	Individual policies		
1946	26,229	14,369	7,135	8,684	8,400	3,460
1950	37,793	25,993	15,104	13,067	8,900	2,900
1955	39,513	29,813	19,171	13,642	8,500	1,200
1960	42,436	31,836	20,970	14,298	9,500	1,100
Short-Term Disability Income Protection						
1965	46,927	33,527	22,409	11,937	11,700	1,700
1970	58,089	39,789	27,876	14,901	15,900	2,400
1971	59,280	40,180	28,408	13,866	16,500	2,600
1972	61,548	41,208	29,151	14,527	17,640	2,700
1973	64,168	43,298	29,279	16,890	18,170	2,700
1974	65,282	43,672	29,320	17,291	18,910	2,700
1975	62,971	41,071	28,607	15,024	19,400	2,500
1976	62,250	38,940	27,534	13,742	20,610	2,700
1977	64,627	40,047	28,176	14,302	21,880	2,700†
1978	68,307	43,289	28,676	17,606	22,318	2,700†
1979	65,808	40,208	27,005	15,907	22,900†	2,700†
1980	65,400	39,700	27,077	15,209	23,000†	2,700†
1981	60,306	34,606	25,859	10,539	23,000†	2,700†
Long-Term Disability Income Protection						
1965	4,514	4,514	1,864	2,650	-	-
1970	10,966	10,966	6,954	4,012	-	-
1971	12,284	12,284	7,951	4,333	-	-
1972	14,538	14,538	9,471	5,067	-	-
1973	17,011	17,011	10,595	6,416	-	-
1974	17,799	17,799	11,116	6,683	-	-
1975	18,396	18,396	11,526	6,870	-	-
1976	17,779	17,779	11,516	6,263	-	-
1977	19,364	19,364	12,481	6,883	-	-
1978	19,100	19,100	12,635	6,465	-	-
1979	19,920	19,920	13,409	6,511	-	-
1980	21,093	21,093	14,693	6,400	-	-
1981	21,682	21,682	15,925	5,757	-	-

†Estimate.

NOTE: For 1975 and later, data include the number of persons covered in Puerto Rico and other U.S. territories and possessions. Data in the category "Insurance companies" refers to the net total of people protected, i.e., duplication among persons who are covered by both group and individual policies has been eliminated. Any duplication resulting from the combination of numbers covered for short-term and long-term protection has not been eliminated. This category excludes Administrative Service Only agreements and Minimum Premium Plans except for those companies who include them in their regular reporting. The category "Formal paid sick leave plans" refers to people with formal paid sick leave plans but without insurance company coverage. The category "Other" includes union-administered plans and the Federal Mutual Benefit Association.

SOURCES: Health Insurance Association of America and U.S. Department of Health and Human Services.

Table 1.8
Number of Persons with Dental Expense Protection by Type of Insurer in the United States

(000 omitted)

End of Year	All insurers	Insurance companies*	Blue Cross/ Blue Shield	Other plans
1967	4,570	2,330	20	2,220
1968	5,867	3,170	35	2,662
1969	8,858	5,159	141	3,558
1970	11,972	7,383	275	4,314
1971	15,263	8,841	1,100	5,322
1972	16,853	10,200	1,110	5,543
1973	20,418	12,097	1,740	6,581
1974	27,855	16,756	3,790	7,309
1975	30,246	18,936	3,318	7,992
1976	41,559	26,562	4,363	10,634
1977	50,301	32,216	5,283	12,802
1978	58,059†	36,647	6,000†	15,412†
1979	70,171†	43,429	8,188†	18,554†
1980	80,528††	55,961	10,000†	28,013†
1981	86,302††	61,086	12,487†	35,531†

*Insurance company data are group plans. †Estimate.

††Estimate of the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance policy providing the same type of coverage has been eliminated.

NOTE: For 1975 and later, data include the number of persons covered in Puerto Rico and other U.S. territories and possessions.

SOURCES: Health Insurance Association of America, Blue Cross Association, Blue Shield Association and the U.S. Department of Health and Human Services.

CHAPTER 2
Health Insurance Benefit Payments

A total of $76 billion in health insurance benefits was paid by private insuring organizations in the United States in 1981 (Table 2.1), a 13.1% increase over 1980 and four times the amount paid 10 years earlier. The increase was mainly because of the rising cost of medical care, expansion of benefits and higher utilization.

Medical expense benefits, which include payments under hospital, surgical, physician's expense and major medical insurance, totaled $64.9 billion in 1981, an increase of 14.2% over 1980. Dental expense benefits for 1981 totaled $5.8 billion.

Health insurance benefits are provided by private insurers in two ways: through indemnity payments or through service arrangements.

Benefits by insurance companies are primarily provided through indemnity payments, whereby the insured person is paid a specified sum of money toward his covered expenses. (Payments can also be made directly to the provider of care through an assignment of benefits.)

Blue Cross-Blue Shield and other plans usually make direct payments for covered services to the participating hospital or physician.

According to a report by the Social Security Administration (Table 2.3), American workers suffered a $36.0 billion loss in earnings resulting from short-term, nonoccupational sickness or injury during calendar year 1979, an increase of 9.9% over the previous year. Benefits paid under programs providing protection against such income loss amounted to $13.4 billion, a 13.8% increase over 1978. Insurance company plans provided $4.5 billion of benefits, 34% of the total.

The numbers in this chapter refer to benefits paid in the current year and include amounts paid for claims of prior years. However, they exclude amounts which will be paid the following year for claims submitted in the current year. Since the premium figures in the next chapter are reported on an earned basis for the calendar year, thereby reflecting a true picture of premiums for the year, it is not appropriate to compare benefit and premium figures.

A comparison of the benefit and premium figures for loss of income policies is particularly inappropriate. Additions to claim reserves for persons already disabled are extracted from current year premiums but not reflected in the benefit payments. These claim reserves will be used to make income payments for all future years of disability included in coverage under the contracts.

Table 2.1
Health Insurance Benefit Payments by Type of Insurer and by Type of Coverage in the United States
(000,000 omitted)

	Year	Total	Medical expense	Dental expense	Loss of income*
All Insurers††	1950	$ 1,347	N.A.	N.A.	$ 383
	1955	3,142	$ 2,547**	N.A.	595
	1960	5,676	4,837**	N.A.	839
	1965	9,624	8,578**	N.A.	1,046
	1970	17,177	15,127	$ 233	1,817
	1975	32,081	28,205	1,169	2,707
	1976	37,966	33,118	1,934	2,914
	1977	41,674	36,093	2,472	3,109
	1978	48,173	41,717	3,051	3,405
	1979	56,292	47,803	3,785	4,704
	1980	67,087	56,850	4,895	5,342
	1981	75,888	64,921	5,811	5,156
Insurance Companies	1950	755	372**	N.A.	383
	1955	1,785	1,190**	N.A.	595
	1960	3,069	2,230**	N.A.	839
	1965	5,160	4,114**	N.A.	1,046
	1970	9,089	7,132	140	1,817
	1975	16,470	13,164	599	2,707
	1976	20,217	16,116	1,187	2,914
	1977	22,113	17,552	1,452	3,109
	1978	26,352	21,176	1,771	3,405
	1979	31,692	24,803	2,185	4,704
	1980	37,002	28,865	2,795	5,342
	1981	41,622	32,992	3,474	5,156
Blue Cross/ Blue Shield and Other Plans	1950	590	N.A.	N.A.	–
	1955	1,357	1,357**	N.A.	–
	1960	2,607	2,607**	N.A.	–
	1965	4,464	4,464**	N.A.	–
	1970	8,088	7,995	93	–
	1975	16,932	16,362	570	–
	1976	20,020	19,273	747	–
	1977	22,804	21,784	1,020	–
	1978	25,928	24,648	1,280	–
	1979	29,761	28,161	1,600	–
	1980	37,086	34,986	2,100	–
	1981	42,477	40,140†	2,337†	–

N.A.—Not available.
*Insurance company coverage only.
**Includes dental expense benefit payments.
†Estimate.
††Benefits for "All Insurers" eliminate the estimated duplication that results from insurance companies and the Health Care Financing Administration ("Other Plans" data) both reporting Administrative Services Only benefits in their data.
NOTE: Some data are revised from previous years. For 1975 and later, data include benefit payments in Puerto Rico and other U.S. territories and possessions. Figures do not add to totals in some cases due to rounding. "Medical expense" includes payments for hospital, surgical, physician's expense and major medical benefits. Insurance company benefit payments for 1975 and later include Administrative Service Only agreements and Minimum Premium Plans. Amounts in prior years contained only a portion of this data.
SOURCES: Health Insurance Association of America, Blue Cross Association, Blue Shield Association and the U.S. Department of Health and Human Services.

Table 2.2
Health Insurance Benefit Payments of Insurance Companies in the United States
(000,000 omitted)

Year	Grand total	Group				Individual and family policies		
		Total	Medical expense	Dental expense	Loss of income	Total	Medical expense	Loss of income
1945	$ 278	$ 139	N.A.	N.A.	N.A.	$ 139	N.A.	N.A.
1950	755	438	N.A.	N.A.	N.A.	317	N.A.	N.A.
1955	1,785	1,252	N.A.	N.A.	N.A.	533	N.A.	N.A.
1960	3,069	2,350	$ 1,809	N.A.	$ 541	719	$ 421	$ 298
1961	3,394	2,616	2,082	N.A.	534	778	457	321
1962	3,763	2,911	2,338	N.A.	573	852	519	333
1963	4,152	3,203	2,614	N.A.	589	948	601	347
1964	4,658	3,585	2,953	N.A.	632	1,073	693	380
1965	5,160	4,000	3,322	N.A.	679	1,160	792	368
1966	5,559	4,357	3,608	N.A.	749	1,203	814	389
1967	6,030	4,790	3,953	$ 42	796	1,239	824	415
1968	6,717	5,362	4,360	54	948	1,355	894	461
1969	7,575	6,202	5,027	79	1,096	1,374	897	476
1970	9,089	7,476	6,043	140	1,293	1,613	1,090	523
1971	9,497	8,018	6,541	175	1,301	1,480	1,006	474
1972	10,622	8,943	7,315	201	1,427	1,679	1,148	531
1973	11,863	9,764	7,924	262	1,578	2,099	1,462	637
1974	13,636	11,439	9,260	332	1,847	2,197	1,517	680
1975	16,470	14,191	11,607	599	1,985	2,279	1,557	722
1976	20,217	17,795	14,425	1,187	2,183	2,422	1,691	731
1977	22,113	19,479	15,683	1,452	2,344	2,634	1,869	765
1978	26,352	22,868	18,696	1,771	2,401	3,484	2,480	1,004
1979	31,692	27,934	22,159	2,185	3,590	3,758	2,644	1,114
1980	37,002	33,002	25,895	2,795	4,312	4,000	2,970	1,030
1981	41,622	37,691	30,057	3,474	4,160	3,931	2,935	996

N.A.—Not available.

NOTE: For 1975 and later, data include benefit payments in Puerto Rico and other U.S. territories and possessions. Insurance company benefit payments for 1975 and later include Administrative Service Only agreements and Minimum Premium Plans. Aggregates in prior years contained only a portion of these data. Figures do not add to totals in some cases due to rounding. The data include loss of income benefits and exclude accidental death and dismemberment benefits.

SOURCES: *Health Insurance Review*, *Spectator Health Insurance Index* and Health Insurance Association of America.

Table 2.3
Income Loss and Benefits* Paid for Short-Term Nonoccupational Sickness
(000,000 omitted)

Calendar year	Total income loss	Benefit Payments*					
				Group Benefits			
				Private Industry			Government employees
		Total**	Individual insurance	Private insurance	Public funds	Sick leave	
1950	$ 4,816	$ 942	$ 153	$ 230	$ 63	$ 180	$ 315
1955	6,565	1,620	250	442	109	273	545
1960	8,591	2,430	393	638	172	400	826
1965	11,333	3,349	483	768	269	566	1,264
1970	16,757	5,888	694	1,476	411	1,066	2,242
1971	17,146	6,137	731	1,489	411	1,130	2,376
1972	19,507	6,874	772	1,614	412	1,364	2,712
1973	21,059	7,461	795	1,736	446	1,469	2,906
1974	21,804	8,232	851	2,025	485	1,634	3,107
1975	23,595	9,002	973	2,011	538	1,779	3,542
1976	26,447	9,819	881	2,268	581	2,052	3,868
1977	28,225	10,559	940	2,344	582	2,359	4,144
1978	32,782	11,733	1,210	2,403	609	2,770	4,562
1979	36,020	13,350	1,322	3,216	699	3,070	4,873

NOTE: Detail may not add to totals due to rounding.

*Insurance benefits are reported on an incurred rather than paid basis. Data are not comparable to that shown in Tables 2.1 and 2.2.

**Beginning with 1973, includes benefits for the sixth month of disability payable under OASDI, not shown separately.

SOURCES: U.S. Department of Health and Human Services, Social Security Administration, unpublished data.

CHAPTER 3
Health Insurance Premium Income

In 1981, health insurance premium income of all private insuring organizations was $84.9 billion. Americans spent the equivalent of 4.18% of disposable personal income (personal income less personal taxes) in 1981 for health insurance premiums, compared with 4.09% in 1980 (Table 3.1).

Insurance company premiums reported in Tables 3.1, 3.2 and 3.3 are on an earned basis for the calendar year. (Earned premiums are defined as the calendar-year portion of premiums for which the protection of the policy has been provided.)

Because benefit data in the preceding chapter refer to paid benefits and do not include estimates for reserve and liability items, it is inappropriate to compare those benefit data to premium data in this chapter.

Insurance companies earned $49.0 billion in premiums in 1981. The premiums or "subscriptions" received by Blue Cross-Blue Shield organizations and other plans are also reported on a calendar-year basis and amounted to $45.2 billion in 1981.

Group and Individual Premiums

Group health insurance premiums paid to private insuring organizations have been increasing substantially for many years. This growth is attributed to the expansion of hospital, surgical and physician's expense protection for employees; to the extension of health insurance coverage to small groups not previously eligible; and to the need to fund larger benefit levels to meet health care cost increases. In 1981, insurance companies earned $42.5 billion in group premiums—some 87% of total insurance premiums—and $6.5 billion in individual and family policy premiums.

Table 3.1
Health Insurance Premiums and Ratio to Disposable Personal Income

Premium Income of Insurance Companies, Subscription Income of Blue Cross/Blue Shield and Other Plans in the United States

(000,000 omitted)

Year	Insurance companies	Blue Cross/ Blue Shield and other plans	Total premiums**	Disposable personal income	Ratio
1940	$ 286	$ 32	$ 318	$ 75,328	0.42%
1945	550	154	704	149,118	0.47
1950	1,266	687	1,953	206,590	0.95
1955	2,743	1,523	4,266	274,958	1.55
1960	4,671	2,814	7,485	351,992	2.13
1961	5,029	3,246	8,275	365,750	2.26
1962	5,595	3,601	9,196	386,791	2.38
1963	6,145	3,918	10,063	405,879	2.48
1964	6,769	4,332	11,101	440,587	2.52
1965	7,352	4,777	12,129	475,779	2.55
1966	7,796	4,969	12,765	513,690	2.48
1967	8,295	5,247	13,542	547,911	2.47
1968	9,082	5,966	15,048	593,418	2.54
1969	10,197	7,089	17,286	638,933	2.71
1970	11,546	8,439	19,985	695,288	2.87
1971	12,777	10,058	22,835	751,751	3.04
1972	14,771	11,465	26,236	810,322	3.24
1973	16,104	12,908	29,012	914,495	3.17
1974	17,915	14,533	32,448	998,345	3.25
1975	20,795*	17,611	36,967	1,096,068	3.37
1976	24,502*	21,455	43,468	1,194,359	3.64
1977	28,676*	25,333	50,449	1,314,019	3.84
1978	32,713*	30,303	58,495	1,473,991	3.97
1979	37,941*	33,199	65,330	1,650,155	3.96
1980	43,666*	38,630	74,669	1,824,076	4.09
1981	48,998*	45,229†	84,883	2,029,148	4.18

*Insurance company premiums for 1975 and later include Administrative Service Only agreements and Minimum Premium Plans. Aggregates in prior years contained only a portion of these data.

**"Total Premiums" eliminate the estimated duplication that results from insurance companies and the Health Care Financing Administration ("Other Plans" data) both reporting Administrative Service Only premium equivalencies in their data.

†Estimate.

NOTE: Some data are revised. For 1975 and later, data include premiums paid in Puerto Rico and other U.S. territories and possessions. Data for "Insurance companies" prior to 1972 refer to written premiums (which, for group policies, include minor adjustments to reflect premiums of the particular year). "Insurance companies" premiums for 1972 and later refer to earned premiums and are revised to exclude premiums for accidental death and dismemberment and other such limited coverages. Data for Blue Cross/Blue Shield and other hospital-medical plans refer to earned income. Data for Blue Cross/Blue Shield for 1974 and later include premium taxes.

SOURCES: U.S. Department of Health and Human Services, *Argus Health Chart*, U.S. Department of Commerce, Health Insurance Association of America, Blue Cross Association and Blue Shield Association.

Table 3.2
Health Insurance Premiums of Insurance Companies by Type of Policy and by Type of Protection in the United States
(000,000 omitted)

Year	Total premiums	Group policies			Individual and family policies		
		Total	Loss of income	Hospital-medical	Total	Loss of income	Hospital-medical
1935	$ 175	$ 26	$ 26	*	$ 149	N.A.	N.A.
1940	286	65	48	$ 17	221	N.A.	N.A.
1945	550	215	125	90	335	N.A.	N.A.
1950	1,266	629	291	338	637	$ 361	$ 276
1955	2,743	1,573	553	1,020	1,170	554	616
1960	4,671	2,895	777	2,118	1,776	744	1,032
1965	7,352	4,683	1,050	3,633	2,669	847	1,822
1966	7,796	5,054	1,183	3,871	2,742	886	1,856
1967	8,295	5,464	1,270	4,194	2,831	948	1,883
1968	9,082	6,088	1,473	4,615	2,994	1,018	1,976
1969	10,197	6,938	1,724	5,214	3,259	1,131	2,128
1970	11,546	8,149	1,968	6,181	3,397	1,104	2,293
1971	12,777	9,170	2,189	6,981	3,607	1,154	2,453
1972	14,771	10,946	2,332	8,614	3,825	1,097	2,728
1973	16,104	11,807	2,414	9,393	4,297	1,304	2,993
1974	17,915	13,193	2,603	10,590	4,722	1,445	3,277
1975	20,795	15,918	2,828	13,090	4,877	1,807	3,070
1976	24,502	19,366	3,144	16,222	5,136	1,854	3,282
1977	28,676	23,234	3,543	19,691	5,442	1,859	3,583
1978	32,713	26,939	4,539	22,400	5,774	1,990	3,784
1979	37,941	31,724	4,933	26,791	6,217	2,096	4,121
1980	43,666	36,801	5,277	31,524	6,865	1,956	4,909
1981	48,998	42,465	5,240	37,225	6,533	1,834	4,699

N.A.—Not available.

*Less than $500,000.

NOTE: For 1975 and later, data include premiums paid in Puerto Rico and other U.S. territories and possessions. Insurance company premiums for 1975 and later include Administrative Service Only agreements and Minimum Premium Plans. Aggregates in prior years contain only a portion of these data. Data prior to 1972 refer to written premiums (which, for group policies, include minor adjustments to reflect premiums of the particular year) and include accidental death and dismemberment premiums in the Loss of Income categories. Data for 1972 and later refer to earned premiums and are revised to exclude premiums for accidental death and dismemberment and other such limited coverages. The category "Medical expense" includes premiums for hospital, surgical, physician's, dental and major medical protection.

SOURCE: Health Insurance Association of America.

CHAPTER 4
Federal, State and Local Government Health Care Programs

Medical and health care services are provided through a variety of public programs by all levels of government. In addition, the Federal, state and local government agencies often fund research projects and construct medical facilities with public funds. Of the $286.6 billion in national health care expenditures in 1981 (see Chapter 5), $122.5 billion was spent for health and medical care programs at all levels of government (Table 4.1).

As the number of programs funded by public monies has multiplied and expanded, so, too, has the public share of national health expenditures. In fiscal 1971, governmental expenditures for health care were 38.1% of national health expenditures, compared to 42.7% in 1981. The introduction of Medicare produced the largest single-year increase in 1967, during which governmental expenditures rose from 29.5% to 37.0% of national health expenditures.

Federal Programs

Prior to 1967, Federal health expenditures accounted for less than 5% of Federal spending. In 1982, Federal expenditures for health care were double state and local expenditures and accounted for nearly 13% of Federal spending (Table 4.2).

The majority of Federal health spending is for health services to six major groups: low-income individuals and others eligible for Medicaid services, those over 65 (Medicare), military personnel and their dependents, veterans, Federal civilian employees, and native Americans. In 1982, Federal budget outlays for health care facilities and services for these groups were 84% of Federal health spending.

Medicaid. Title XIX of the Social Security Act provides for a program of medical assistance for certain low-income individuals and families. The program, known as Medicaid, became Federal law in 1965.

Medicaid is basically administered by each state within certain broad Federal requirements and guidelines. The program is financed jointly by state and Federal funds and is designed to provide medical assistance to those groups or categories of persons who are eligible to receive payment under one of the cash assistance programs (i.e., Aid to Families with Dependent Children and Supplemental Security Income). In addition, states may provide Medicaid to the "medically needy," that is, to persons who fit into one of the categories eligible for public assistance, who have enough income to pay for their basic living expenses but not enough to pay for their medical care. As of January 1982, thirty-one states, plus Guam, Puerto Rico and the Virgin Islands, granted Medicaid eligibility to their "medically needy" populations.

Many members of the Medicaid population are aged or disabled and are also covered by Medicare. In cases where this dual coverage exists, most state Medicaid programs pay for the

Medicare premiums, deductibles and copayments, and for services not covered by Medicare.

In order to qualify for Federal matching funds, state programs must include: inpatient hospital services; outpatient hospital services; laboratory and X-ray services; skilled nursing and home health services for individuals aged 21 and older; family planning services; early and periodic screening, diagnosis and treatment for children under 21; and physicians' services at home, in the office, hospital, nursing home or elsewhere.

In 1981, the Medicaid program paid $27.3 billion in benefits to 22.1 million recipients. (Table 4.5).

State participation in the Medicaid program is optional. Currently, all states except Arizona participate in the Medicaid program. The District of Columbia, Guam, Puerto Rico, the Virgin Islands and the Northern Mariana Islands also provide Medicaid coverage.

Medicare. Medicare, which became effective July 1, 1966, is a Federally administered program that provided hospital and medical insurance protection for 29 million persons in 1981 — those aged 65 and older, persons under age 65 who have been receiving cash benefits under the Social Security or Railroad Retirement programs because they are disabled, and certain chronic kidney disease patients under age 65. Medicare consists of two parts: compulsory hospitalization insurance (HI), also called Part A; and voluntary supplementary medical insurance (SMI), Part B, which helps pay for physicians' services and some medical services and supplies not covered under Part A. Part A is financed by contributions from employers and employees; Part B is voluntary and is financed by monthly premiums paid by those who choose to enroll and by the Federal government.

As of January 1, 1983, the out-of-pocket deductible for Part A of Medicare rose to $304 (from $260) for the first 60 days' hospitalization and $76 per day (from $65) for the 61st through the 90th day.

Part B provides benefits equal to 80% of allowed medical-surgical charges after the insured has paid a $75 deductible amount toward those charges. An individual's monthly premium is $12.20—it will increase to $13.50 July 1, 1983.

Prior to 1973, aliens and some Federal civil service employees and annuitants were not eligible for Part A of Medicare even though they were age 65 or older. In 1973, the law was amended to allow them to enroll in Part A by paying a monthly premium. The premium, $113 a month, is based on the full cost of hospital care for a high-risk group. These individuals have always had the option of enrolling in Part B.

Since the first full year of Medicare in 1967, benefits paid have increased from $4.5 billion to $43.5 billion in 1981, an increase of 855% (Table 4.4). Part of the increase is because of the eligibility of certain disabled persons beginning in 1973, so that in 1981 over 13% of total benefits paid went to individuals under age 65. Benefits paid under Part A totaled $30.3 billion in 1981, of which $26.7 billion went to those aged 65 and older. Part B paid $13.1 billion, of which $10.9 billion went to the elderly.

Insurance companies, Blue Cross-Blue Shield plans and other independent organizations participate as fiscal intermediaries for the government. In 1981, five private health insurance companies served as fiscal intermediaries for Part A of Medicare, distributing $3.3 billion in benefits in 45 states and the District of Columbia. Eleven companies distributed $3.6 billion in benefits under Part B as fiscal intermediaries in 23 states.

Military Personnel and Dependents. All active and retired military personnel and their dependents are eligible for medical treatment at any Department of Defense (DOD) installation medical facility. Additionally, DOD operates the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to provide reimbursement (after payment of a deductible) for covered medical care provided in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel (unless eligible for Part A of Medicare). The program is designed for those unable to use government medical facilities because of distance, overcrowded facilities or the unavailability of appropriate treatment at a military medical center.

Of the $5.7 billion spent on medical care by the Department of Defense in fiscal 1981, $852 million was for medical services rendered under CHAMPUS.

Federal Civilian Employees. Civilian employees of the Federal government may participate in a variety of insurance programs (including HMOs) through the payment of biweekly premiums by the employing agency and the employee. Nearly 3.7 million Federal civilian employees and annuitants were enrolled in 1981, and 6.3 million dependents were also insured in that year. Most annuitants who were covered under the Federal Employees Health Benefits Program when they were employed by the Federal government may elect to continue this coverage. Annuitants not previously insured under the program may participate in the Retired Federal Employees Health Benefits Program, which, among other options, provides for government payment of the premium for Medicare Part B. Of the 73,732 retirees enrolled in this program on June 30, 1981, 48% had chosen the Medicare Part B option. The remainder were covered under private plans.

In addition to Federal payment of the employer contributions under these programs, the Federal government also incurs administrative expenses and operates in some Federal agencies' in-plant health care facilities for Federal civilian employees.

Federal expenditures for these Federal civilian health programs in fiscal 1981 were nearly $2.6 billion.

Veterans Medical Care. The Veterans Administration (VA) operates 172 medical centers and 226 independent or satellite clinics for the care of individuals with active service in the armed forces who were discharged from duty other than dishonorably. Priority is given to patients with service-related ailments. Of the $6.6 billion budgeted by the Federal government for VA medical activities in 1981, $6.3 billion was for medical care and hospital services.

Inpatient care was provided to approximately 1.4 million veterans in 1981.

Indian Health Services. A total of $690 million in Federal funds was appropriated to provide health services to over 846,000 American Indians and Alaskan natives in 1981. The services included hospital care and other medical services; the construction of hospitals, sanitation facilities and housing for health service employees; health manpower training and education; health planning; and research.

Workers' Compensation Medical Care. The Federal government in calendar year 1981 paid $162 million of the $5.7 billion in hospital and medical benefits and administrative expenses under Workers' Compensation laws in the various states (Table 4.6). Hospital and medical costs amounted to about one-third of all Workers' Compensation expenditures.

State and Local Programs

The nation's 55 official State Health Agencies (SHAs) that reported for 1981 spent an estimated $4.9 billion in fiscal 1981, including $1.8 billion of Federal funds (Table 4.7). These figures do not include Medicaid expenditures or funds expended for public health purposes by other state agencies. Expenditures for activities of Local Health Departments (LHDs) are included only to the extent that they represent the State Health Agency grants to LHDs.

Not all SHAs perform the same services. In some states certain services are performed by other state agencies. For example, expenditures for mental health services may be controlled by a separate Mental Health Agency.

The public health programs of SHAs can be divided into four program areas, apart from general administrative and service functions: personal health, environmental health, health resources and laboratory services.

Around 73% of SHA expenditures in 1981 were for personal health in nine areas: general and supporting personal health, maternal and child health, communicable disease, handicapped children, dental health, chronic disease, mental health and related programs, SHA operated institutions, and other personal health (for instance, home health care and services to special population groups such as migrants).

There were some 3,100 local health departments in 1981. The territories and possessions (except Puerto Rico), three states and the District of Columbia do not have LHDs.

Table 4.1
Federal, State and Local Government Expenditures for Health and Medical Care

Year	Amount (in billions) Federal	State and local	Total	Total per capita	Total as percent of all national health care expenditures (public & private)
1950	$ 1.6	$ 1.8	$ 3.4	$ 22	26.8%
1955	2.0	2.6	4.6	27	26.0
1960	3.0	3.6	6.6	36	24.5
1965	5.5	5.2	10.8	55	25.9
1966	7.4	6.1	13.6	68	29.5
1967	11.9	7.0	19.0	94	37.0
1968	14.1	8.0	22.1	108	38.0
1969	16.1	8.8	24.9	121	37.9
1970	17.7	10.1	27.8	133	37.2
1971	20.3	11.3	31.7	150	38.1
1972	22.9	12.5	35.4	166	37.9
1973	25.2	14.1	39.3	182	38.1
1974	30.4	16.6	47.1	216	40.5
1975	37.1	19.1	56.2	255	42.4
1976	42.6	20.3	62.9	284	42.0
1977	47.4	22.7	70.1	313	41.4
1978	53.9	25.7	79.5	351	42.0
1979	61.0	29.5	90.6	395	42.1
1980	71.1	34.3	105.4	455	42.3
1981	83.9	38.6	122.5	524	42.7

NOTE: Detail may not add to totals due to rounding.

SOURCE: Health Care Financing Administration, *Health Care Financing Review*, September 1982.

Table 4.2
Federal Government Health Budget Outlays
(000,000 omitted)

Fiscal Year	Medicaid and Predecessors	Medicare	Dept. of Defense	Veterans Services	Indian Health Services	Federal Civilian Employees Health Insurance	Research	Medical Facilities Construction*and Other	Total	% of Total Federal Budget
1960	$ 200	N.A.	$ 880	$ 879	N.A.	–	$ 448	$1,093	$ 3,500	3.8%
1965	555	N.A.	937	1,115	$ 71	$ 149**	1,040	1,293	5,160	4.4
1966	766	$ 65†	1,107	1,161	75	165**	1,315	1,274	5,928	4.4
1967	1,205	3,395	1,432	1,252	83	202**	1,364	1,868	10,801	6.8
1968	1,834	5,347	1,648	1,343	94	223	1,547	2,096	14,132	7.9
1969	2,298	6,598	1,750	1,431	107	230	1,528	2,614	16,556	8.9
1970	2,607	7,149	1,760	1,651	120	233	1,577	2,969	18,066	9.2
1971	3,374	7,875	1,957	1,874	143	350	1,565	3,040	20,178	9.5
1972	4,166	8,819	2,341	2,256	170	502	1,776	4,501	24,531	10.6
1973	4,997	9,479	2,468	2,587	198	561	2,002	3,738	26,030	10.6
1974	5,833	11,348	2,741	2,787	216	729	2,078	3,457	29,189	10.9
1975	7,056	14,781	3,085	3,287	283	1,029	2,453	4,816	36,790	11.3
1976	8,381	17,777	3,232	3,793	332	1,397	2,818	5,883	43,613	11.9
1977	9,714	21,391	3,815	4,708	395	1,654	3,147	4,812	49,636	12.4
1978	10,960	25,551	3,354	5,174	467	1,837	3,715	4,277	55,335	12.2
1979	12,407	29,148	4,332	5,509	555	1,991	3,929	4,875	62,746	12.7
1980††	13,957	35,034	4,696	6,424	635	2,195	4,599	6,734	74,274	12.8
1981††	16,452	40,006	5,608	6,822	688	2,660	4,829	7,064	84,129	12.7
1982††	17,334	44,877	6,034	7,661	718	2,962	5,186	10,089	94,861	12.8

N.A.—Not available.

*Except Veterans Administration, Department of Defense and Indian Health Services facilities construction.

**Fiscal year estimates based on calendar year data provided by U.S. Office of Personnel Management.

†July to December. ††Estimated.

NOTE: Data include administrative expenses.

SOURCES: U.S. Office of Management & Budget, *Special Analyses. Budget of the United States Government*, various years; Social Security Administration, "Social Welfare Expenditures", *Social Security Bulletin*, various years; U.S. Department of Health and Human Services, Indian Health Service; U.S. Office of Personnel Management.

Table 4.3
Average Monthly Number of Medicaid Recipients and Benefits Paid By Federal and State Governments
(000,000 omitted)

Fiscal year	Total		Age 65 and over		Families with dependent children		All others	
	Average monthly recip-ients	Annual benefits paid	Average monthly recip-ients	Annual benefits paid	Average monthly recip-ients	Annual benefits paid	Average monthly recip-ients	Annual benefits paid
1968	3.6	$ 3,451.4	1.2	$1,534.8	1.5	$ 850.7	0.9	$1,065.9
1969	4.3	4,273.4	1.4	1,757.6	2.1	1,275.3	0.8	1,240.5
1970	4.8	4,807.5	1.4	1,881.8	2.5	1,495.6	0.9	1,430.1
1971	5.9	5,939.2	1.6	2,226.1	3.2	2,003.0	1.1	1,710.1
1972	6.8	7,374.9	1.8	2,702.9	3.6	2,430.8	1.4	2,241.2
1973	7.3	8,810.2	1.9	3,288.9	3.9	2,830.1	1.5	2,691.2
1974	7.7	10,148.7	1.9	3,701.9	4.1	3,282.3	1.7	3,164.5
1975	8.5	12,289.2	2.0	4,618.3	4.7	3,962.1	1.8	3,708.8
1976	9.2	14,208.3	2.1	5,190.9	5.1	4,442.4	2.0	4,575.0
1977	9.0	16,289.5	2.0	5,918.5	5.0	4,921.8	2.0	5,449.2
1978	9.0	17,805.3	2.1	6,727.3	4.9	5,042.7	2.0	6,035.3
1979*	8.5	19,995.9	2.0	7,646.2	4.5	5,282.5	2.0	7,067.2

*Estimated by source.

NOTE: Excludes premium and per capita amounts and state expenditures not eligible for Federal matching funds.

SOURCES: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research, Demonstrations and Statistics.

Table 4.4
Medicare Enrollments and Benefit Payments
(000,000 omitted)

Calendar Year	Hospital and/or Medical Insurance		Hospital Insurance (Part A)		Supplementary Medical Insurance (Part B)	
	Number of Enrolled Persons*	Benefit Payments	Number of Enrolled Persons*	Benefit Payments	Number of Enrolled Persons*	Benefit Payments
All Enrollees						
1966 (July-Dec.)	19.1	$ 1,019	19.1	$ 891	17.7	$ 128
1967	19.5	4,549	19.5	3,353	17.9	1,197
1968	19.8	5,697	19.8	4,179	18.8	1,518
1969	20.1	6,603	20.0	4,739	19.2	1,865
1970	20.5	7,099	20.4	5,124	19.6	1,975
1971	20.9	7,868	20.7	5,751	20.0	2,117
1972	21.3	8,643	21.1	6,318	20.4	2,325
1973	23.5	9,583	23.3	7,057	22.5	2,526
1974	24.2	12,418	23.9	9,099	23.2	3,318
1975	25.0	15,588	24.6	11,315	23.9	4,273
1976	25.7	18,420	25.3	13,340	24.6	5,080
1977	26.5	21,774	26.1	15,737	25.4	6,038
1978	27.2	24,934	26.8	17,682	26.1	7,252
1979	27.9	29,331	27.5	20,623	26.8	8,708
1980	28.5	35,700	28.1	25,064	27.4	10,635
1981	29.0	43,455	28.6	30,342	27.9	13,113
Enrollees Age 65 and Over						
1966 (July-Dec.)	19.1	$ 1,019	19.1	$ 891	17.7	$ 128
1967	19.5	4,549	19.5	3,353	17.9	1,197
1968	19.8	5,697	19.8	4,179	18.8	1,518
1969	20.1	6,603	20.0	4,739	19.2	1,865
1970	20.5	7,099	20.4	5,124	19.6	1,975
1971	20.9	7,868	20.7	5,751	20.0	2,117
1972	21.3	8,643	21.1	6,318	20.4	2,325
1973**	21.8	9,225	21.6	6,803	20.9	2,422
1974**	22.3	11,275	22.0	8,295	21.4	2,980
1975**	22.8	13,994	22.5	10,250	21.9	3,744
1976**	23.3	16,328	22.9	11,959	22.4	4,369
1977**	23.8	19,131	23.5	14,012	23.0	5,119
1978**	24.4	21,713	24.0	15,612	23.5	6,101
1979**	24.9	25,431	24.5	18,143	24.1	7,288
1980**	25.5	30,958	25.1	22,077	24.7	8,881
1981**	26.0	37,640	25.6	26,696	25.2	10,944

*As of July 1.

**Benefits estimated by the Health Care Financing Administration.

NOTE: Details may not add to totals due to rounding.

SOURCES: Bureau of Data Management and Strategy, Health Care Financing Administration, Department of Health and Human Services. *1982 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* and *1982 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.*

Table 4.5
Medicare and Medicaid Benefits by State, 1981

State	Medicare		Medicaid*	
	Benefits** paid (000,000)	Number of persons enrolled (7/1/81)*** (000)	Benefits**** paid (000,000)	Unduplicated count of recipients*** (000)
Alabama	$ 608	501	$ 282.7	330.6
Alaska	22	14	44.0	24.7
Arizona	476	343	-	-
Arkansas	388	353	273.6	219.0
California	4,848	2,685	3,402.7	3,616.9
Colorado	346	275	215.7	145.5
Connecticut	563	402	379.8	222.2
Delaware	89	68	51.8	50.4
District of Columbia	160	78	160.1	121.1
Florida	2,627	1,777	489.0	539.2
Georgia	693	601	533.5	442.9
Hawaii	110	85	112.0	104.5
Idaho	110	107	57.6	42.8
Illinois	2,221	1,372	1,322.2	1,110.7
Indiana	860	655	419.5	222.3
Iowa	484	421	273.7	195.6
Kansas	459	330	218.5	148.8
Kentucky	507	471	361.1	412.8
Louisiana	526	449	434.3	410.4
Maine	202	161	148.9	146.3
Maryland	697	433	348.5	328.2
Massachusetts	1,323	788	1,120.3†	746.8
Michigan	1,745	1,055	1,288.3	962.0
Minnesota	664	522	679.9	324.0
Mississippi	351	330	236.4	328.6
Missouri	951	713	374.6	361.1
Montana	112	97	73.0	49.3
Nebraska	255	221	125.5	76.4
Nevada	145	78	61.5	30.2
New Hampshire	144	115	80.9	44.3
New Jersey	1,388	959	791.6	661.1
New Mexico	155	134	88.9	94.5
New York	3,679	2,375	5,274.7	2,241.1
North Carolina	743	699	477.9	382.4
North Dakota	119	89	62.1	32.4
Ohio	1,817	1,325	1,005.4	856.7
Oklahoma	469	406	353.1	277.7
Oregon	458	340	195.4	170.6
Pennsylvania	2,523	1,710	1,255.0	1,090.0
Rhode Island	207	141	186.6	126.6
South Carolina	355	340	288.1	365.6
South Dakota	111	100	68.1	35.4
Tennessee	677	589	423.5	364.2
Texas	1,723	1,485	1,144.5	705.8
Utah	127	122	99.0	68.1
Vermont	79	66	71.1	56.8
Virginia	698	573	429.0	330.9
Washington	561	482	424.1	331.4
West Virginia	311	279	124.7	207.4
Wisconsin	819	629	834.4	445.2
Wyoming	48	42	16.9	11.4
State Unknown	18	28	-	-
Total United States	39,773	28,410	27,183.9	20,613.3
U.S. Territories and Possessions††	135	372	99.7††	1,460.1††
Foreign Countries	11	228	-	-
GRAND TOTAL	$39,919	29,010	$27,283.6	22,073.4

*Medicaid figures are preliminary.
**Medicare data exclude retroactive adjustments made at end of accounting year on basis of reasonable costs of operation. Data are for calendar year 1981.
***Includes some persons aged 65 and over and some disabled persons who are both Medicare enrollees and Medicaid recipients.
****Medicaid data for some states include expenditures not computable for Federal funding.
†Excludes data for the blind.
††Data for Guam are not available.
Note: Details may not add to totals due to rounding.
SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration.

Table 4.6
Hospital and Medical Expenditures Under Workers' Compensation
(000,000 omitted)

	State and Local	Federal	Total
1965	$ 787	$ 12	$ 798
1966	897	13	910
1967	996	15	1,011
1968	1,130	16	1,146
1969	1,244	18	1,262
1970	1,384	23	1,408
1971	1,414	26	1,440
1972	1,545	29	1,574
1973	1,848	34	1,882
1974	2,133	42	2,175
1975	2,371	59	2,430
1976	2,685	70	2,756
1977	3,053	76	3,129
1978	3,384	93	3,476
1979	4,378	117	4,494
1980	4,901	140	5,042
1981	5,551	162	5,713

*For 1970 and succeeding years data include Federal "black lung" benefits.

NOTE: Figures have been revised to include total health and medical expenditures of the Workers' Compensation program, rather than only benefits paid. Details may not add to totals due to rounding.

SOURCE: Health Care Financing Administration, "National Health Expenditures, 1981," *Health Care Financing Review*, September 1982.

Table 4.7
Public Health Programs of State Health Agencies: Expenditures and Persons Served, 1981
(000 omitted)

States	Expenditures by Source				Personal Health Services*	
	Total	Federal	State	Other**	Expenditures (Included in Total)	Persons Receiving any Service†
Alabama	$ 62,508	$ 37,644	$ 20,395	$ 4,468	$ 39,583	1,304
Alaska	19,330	3,066	14,794	1,471	14,321	442
Arizona	105,049	33,747	62,802	8,500	84,932	1,394
Arkansas	40,612	18,987	20,932	692	24,555	648
California	383,374	94,463	273,211	15,700	185,890	2,522
Colorado	57,311	31,728	25,583	-	38,006	771
Connecticut	49,460	24,959	24,501	††	33,803	639
Delaware	24,182	4,168	19,931	84	21,816	212
District of Columbia	72,279	21,898	50,381	-	66,372	638
Florida	155,061	51,591	59,431	44,039	101,954	2,150
Georgia	98,985	46,806	50,950	1,229	71,378	1,971
Hawaii	129,381	14,140	75,293	39,948	109,670	503
Idaho	23,490	14,622	8,278	590	13,689	342
Illinois	89,753	53,979	35,774	-	58,717	5,594
Indiana	45,062	26,487	18,575	-	23,225	709
Iowa	24,308	16,284	8,025	-	19,501	393
Kansas	29,016	17,557	10,234	1,225	15,297	1,501
Kentucky	153,832	40,554	85,936	27,342	131,925	4,228
Louisiana	83,516	41,169	24,749	17,597	64,960	721
Maine	21,747	11,005	9,877	865	17,778	219
Maryland	377,268	52,075	287,479	37,714	318,295	711
Massachusetts	132,626	25,761	104,067	2,797	115,559	2,051
Michigan	183,772	76,512	88,098	19,161	141,601	2,181
Minnesota	58,806	32,538	25,493	775	22,526	1,233
Mississippi	61,271	33,337	13,432	14,502	50,783	1,150
Missouri	69,504	29,117	29,057	11,330	57,747	996
Montana	18,822	13,284	2,857	2,681	10,384	335
Nebraska	18,035	12,748	3,365	1,922	11,665	403
Nevada	14,269	7,252	6,001	1,016	10,215	254
New Hampshire	11,508	7,010	4,432	66	8,172	201
New Jersey	100,136	54,154	40,148	5,834	72,300	997
New Mexico	96,672	20,466	60,786	15,421	78,385	298
New York	365,263	125,317	236,187	3,759	237,926	1,566
North Carolina	122,691	55,482	51,980	15,230	107,902	1,836
North Dakota	28,079	9,199	14,415	4,464	22,576	258
Ohio	114,975	80,362	28,055	6,559	88,146	1,656
Oklahoma	52,259	24,702	18,393	9,164	34,969	912
Oregon	27,983	18,576	5,229	4,179	18,607	641
Pennsylvania	146,086	63,886	78,912	3,288	114,111	6,043
Rhode Island	26,302	10,784	15,518	-	13,771	286
South Carolina	107,221	40,281	46,882	20,057	70,560	842
South Dakota	14,144	9,617	2,688	1,838	10,432	305
Tennessee	104,370	44,377	43,107	16,885	61,736	1,559
Texas	188,401	85,223	89,356	13,822	138,824	7,604
Utah	28,077	16,849	10,060	1,169	17,167	436
Vermont	15,359	11,472	3,690	198	11,750	230
Virginia	132,232	37,372	52,519	42,342	83,750	1,647
Washington	43,688	26,517	14,909	2,262	32,814	1,115
West Virginia	101,294	18,212	76,115	6,967	87,364	636
Wisconsin	42,987	30,183	10,261	2,542	29,354	492
Wyoming	9,420	3,465	4,930	1,025	6,944	387
Puerto Rico and U.S. Territories and Possessions	370,315	77,643	292,672	-	320,799	2,289
GRAND TOTAL	$4,852,089	$1,758,628	$2,660,745	$432,718	$3,564,506	68,452

*Other program areas for which state health agencies may be responsible include environmental health, health resources and laboratory.
**Includes local funds, fees and reimbursements, and other sources.
†Estimated unduplicated count.
††Less than $500,000.
NOTE: Data are from 55 state and territorial health agencies. Guam and the Northern Mariana Islands did not report. Data exclude expenditures for local health departments, those funds expended for public health purposes by other state agencies such as separate mental health agencies, and Medicaid. Details may not add to totals due to rounding.
SOURCE: Association of State and Territorial Health Officials, National Public Health Program Reporting System. Preliminary FY 1981 data.

CHAPTER 5
Medical Care Costs

Each year Americans spend more money for medical care. The increases result from a combination of factors— higher costs, greater demand for health services, rising incomes, and growth and availability of private health insurance. Other major influences include the introduction of newer and costlier medical techniques and procedures, higher educational level of the population (which is generally associated with greater expenditures for personal health care), growing awareness of the availability of medical care, and a rising proportion of elderly persons in the population, who, as a group, are prone to a higher incidence of health-related problems.

Total Medical Expenditures

In this chapter, spending for health care is discussed in terms of National Health Expenditures, Personal Health Care Expenditures, Personal Consumption Expenditures for Medical Care, the Consumer Price Index, and the Family Budgets.

National Health Expenditures

Total health care spending, represented by the **National Health Expenditure (NHE)** figure, includes both private and public expenditures for personal health care, medical research and construction of medical facilities, administrative and health insurance costs, and government-sponsored public health activities. Because of its all-inclusive nature, the National Health Expenditure will be discussed in terms of, and compared to, the Gross National Product. The National Health Expenditure figure covers spending for health care over the 12-month calendar year.

National health spending reached $286.6 billion in 1981 (Table 5.1), or an average of $1,225 per person.

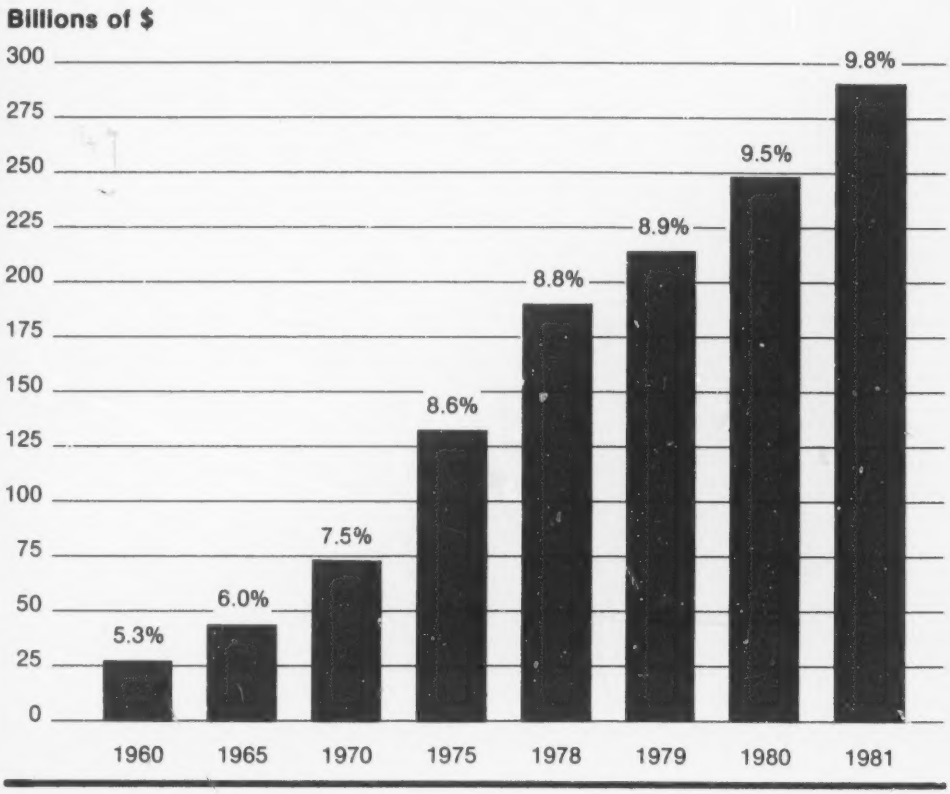
Total health expenditures showed a 15.1% increase, compared with a 15.8% increase in 1980. Public spending, which financed 42.7% of all health care costs in 1981, increased 16.2% over 1980, while private spending rose 14.3%. Since 1974, the last year price controls for health services were in effect, national health expenditures have risen 146.2%.

Hospital care continued to represent the largest share of spending for health care, totaling $118.0 billion in 1981. The cost of physicians' services was the next highest at $54.8 billion.

In 1965, National Health Expenditures constituted 6.0% of the Gross National Product. This proportion has continued to increase over the years, reaching 9.8% in 1981.

According to projections made by the Health Care Financing Administration, National Health Expenditures will reach $456 billion in 1985, and $756 billion by 1990. Per capita expenditures are projected to be $1,882 in 1985, almost 54% more than the 1981 figure of $1,225. By 1990, per capita expenditures are projected to be

National Health Expenditures and Percent of Gross National Product



$2,982 (Table 5.3).

Estimates from the Health Resources Administration (U.S. Department of Health and Human Services) predict that in the year 2000 the total direct and indirect economic costs of illness will exceed $2 trillion (Table 5.4).

Personal Health Care Expenditures

The **Personal Health Care Expenditure (PHCE)** figure represents private and public spending for health and medical services for the direct benefit of the individual, representing 89% of 1981 National Health Expenditures.

Spending for personal health care in the nation amounted to $255.0 billion in 1981 (Table 5.5). This sum includes all outlays for health and medical services for the direct benefit of the individual, including both public and private spending.

Included are expenditures for hospital care, physicians', dentists' and other professional services, drugs and medical sundries, eyeglasses and appliances, nursing home care, and spending for in-plant health services. Not included are expenditures for medical research, construction of medical facilities, public health activities such as disease prevention and control, and the net cost of health insurance — the difference between

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premiums and benefits paid. (The latter items are included in the National Health Expenditure figure.)

Table 5.6 shows aggregate and per capita personal health care spending by state in 1978, the latest year for which data are available. Each person in the United States averaged $161 for physicians' care, $337 for hospital care, and $745 for all personal health care.

According to an analysis of personal health care expenditures by the Health Care Financing Administration, the effect of inflation in 1981 continued its impact, at a consistent rate since 1979 (Table 5.7). For the twelve month periods ending December 1979, 1980 and 1981, price increases accounted for 72% of the expenditure growth. The increase in intensity of care — frequency and quality of care — contributed 20% to the overall growth rate in 1979. This percentage increased to 22% by 1981.

An analysis of the $255.0 billion of national spending for personal health care (Table 5.8) shows the per capita expenditure rose to $1,090 in 1981. In 1978, persons aged 65 and older accounted for 29.4% of total personal health care spending, while persons under age 19 and those between the ages of 19 and 64 accounted for 11.8% and 58.8%, respectively.

The largest portion of the personal health care dollar is financed by third-party sources (Table 5.9). Private health insurance, philanthropy, industry and the government paid 68% of all expenditures for personal health care in 1981.

Personal health care figures include expenditures of all consumers, whether insured or not. Included are expenses for non-prescribed drugs and medicines, household supplies such as tissues and rubbing alcohol, and other items not covered by insurance.

In terms of the growth of personal health care components, hospital care has been the fastest growing category of expenditures. In 1965, monies spent for hospital care represented 39% of personal health care expenses. By 1981, the proportion rose to 46%. During the 1965-81 period, outlays for physicians' services dropped from 24% to 21% of personal health care spending.

Personal Consumption Expenditures

Personal Consumption Expenditures (PCE) for medical care represent private payments, although monies from three government programs (Medicare, Workers' Compensation and Temporary Disability Insurance) are treated as transfer payments and are included. The PCE is computed as an annual average.

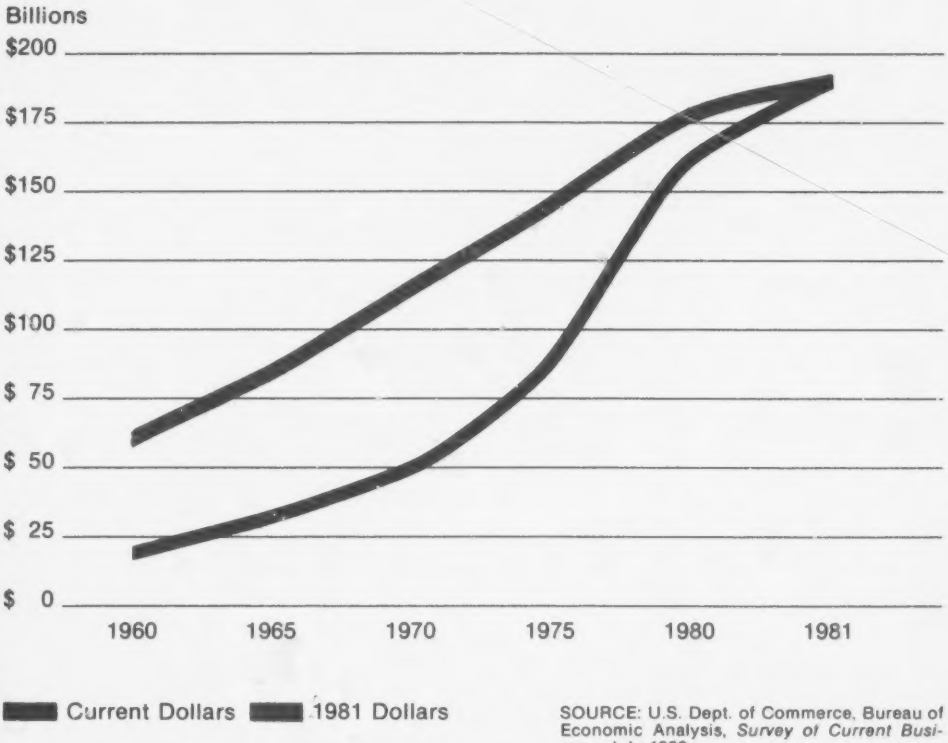
While the same basic categories of expenditures constitute the PCE for medical care and the PHCE portion of the NHE figure, different accounting practices are used for each. Some important distinctions include:

(1) With respect to hospital costs, the PHCE figure focuses on personal outlays for hospital services and does not include the cost of providing services; the PCE includes the latter item for private, nonprofit hospitals.

(2) The PCE includes the net cost of health insurance (i.e., earned premiums less benefits paid) but the PHCE does not. However, this figure is included in the NHE data.

Personal Consumption Expenditures for medical care were $191.1 billion

Personal Consumption Expenditures for Medical Care in Current Dollars and Constant 1981 Dollars



SOURCE: U.S. Dept. of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, July 1982.

for calendar year 1981 (Table 5.10), three and one-half times the amount spent 10 years earlier. The 1981 amount represented 10.4% of the total spent by Americans on all personal needs, compared with 8.1% a decade earlier.

As a proportion of the public's disposable personal income, these expenditures were 9.4% in 1981, up from 7.2% in 1971 (Table 5.11).

Personal Consumption Expenditures for nongovernmental hospital care (including expenses of nonprofit hospitals, sanitariums and nursing homes, and payments by patients to proprietary hospitals, sanitariums and nursing homes) were $84.1 billion in 1981 (Table 5.12), four times the amount in 1971. Payments for physicians' services were $50.4 billion, three and one-half times the amount spent a decade earlier.

Consumer Price Index

The Consumer Price Index (CPI) measures the average change in prices of all types of consumer goods and services purchased by urban wage earners and clerical workers. The index measures the effect of *price change only* on the cost of living. It does *not* measure changes in the total amount families spend.

According to the Consumer Price

Index (CPI), in 1982, medical costs increased by 11.6% over 1981 compared to a 6.1% increase for all items (Table 5.14).

Individual components of medical care have differed in their rate of increase. Hospital room rates have risen most rapidly. The disproportionate rate of increase for hospital charges is due in no small part to the fact that the CPI index for hospital charges is based on the published charges, i.e., those charges made to patients insured by private insurance companies or to patients without any private or government coverage for hospital care costs. These charges are disproportionately higher than the actual per patient cost. The reason for this is that hospitals must make up revenues lost due to bad debts, charity cases, fixed reimbursement schedules under Medicare and Medicaid, and negotiated reimbursement levels of many community-rated health insurers. The resulting shortfall is shifted to insurance company patients or to those with no insurance coverage. To illustrate, statistics compiled by the Health Insurance Association of America indicate that the lower payment differential for Medicare patients in community hospitals compared with payments for patients covered by insurance companies grew from an average of $12 per day in 1975 to an estimated $50 per adjusted patient day in 1980.

The Consumer Price Index for 1979 and later years reflects the substantial revisions made in many categories of goods and services. Additionally, as of January 1978, the index was revised to include all urban consumers. In the past only urban wage and clerical workers were included. Thus, the newly created or revised categories should not be compared to prior years.

Family Budgets

Hypothetical **Family Budgets** are estimated annually by the U.S. Bureau of Labor Statistics for two types of families: the urban family of four and the retired couple. Each budget represents the costs of three hypothetical lists of goods and services that were specified in the mid-1960s to portray three relative standards of living—described as lower, intermediate and higher. The budgets are for a precisely defined urban family of four and for a self-supporting retired urban couple.

The medical care component of the budget for a family of four includes family membership in a group hospital and surgical plan, a specified number of physician visits, eye and dental care and prescriptions (except that the higher budget also includes major medical insurance coverage). For the retired couple, the budget includes out-of-pocket expenses for Medicare and for items not covered by Medicare, including dental care, prescriptions and eyeglasses.

The family budget is also used as a means of weighing various components of family consumption costs. Hypothetical budgets for autumn of each year are developed by the Bureau of Labor Statistics for an urban family of four and for a retired couple at the lower, intermediate and higher standards of living. The hypothetical data are presented in Tables 5.16-5.18.

Between autumn 1980 and autumn 1981, consumption costs for the four-person family rose 7.3% in the lower budget, and 7.5% in the

intermediate and higher budgets. Among the budget consumption components (which include food, housing, transportation, clothing, personal care and medical care), medical care registered the second largest increase in all three budgets.

Medical care costs increased nearly 15% for a retired couple in 1981.

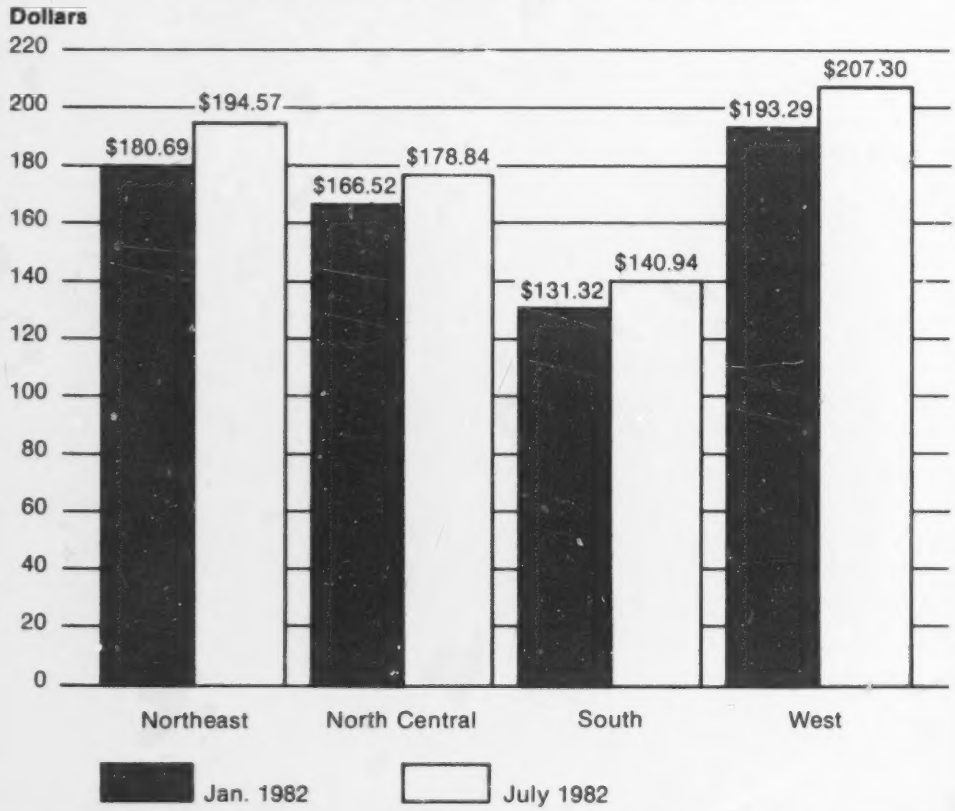
Hospital Charges

Community Hospital Statistics. The average cost to community hospitals to treat a person in 1981 was $284.30 per patient-day, an 87% increase over 1976. On a state-by-state basis, the average cost per day in 1981 varied considerably from a low of $194.90 in South Dakota to a high of $453.00 in Alaska.

In 1981, the average length of time a patient remained in a community hospital was 7.6 days compared to 7.7 days in 1976. For the past five years the average length of stay has remained 7.6 days, following several years of steady decline.

Although the length of the average hospital stay has remained the same over the five-year period, the cost for

Average Cost to Patient Per Day for Semiprivate Hospital Room by Region



NOTE: Northeast includes New England and Middle Atlantic states; North Central, East North Central and West North Central states; South, South Atlantic, East South Central and West South Central states; and West, Mountain and Pacific states. Data exclude Puerto Rico.

SOURCE: Health Insurance Association of America, *Survey of Hospital Semiprivate Room Charges*, July 1982.

the average stay went up, climbing 85% from 1976 to reach $2,160.70 per patient stay.

The average length of stay varied by area, from a low of 5.5 days in Utah to a high of 9.8 days in New York. Differences reflect the incidence of various diseases, age distribution of the population, income levels and postponement of non-emergency admissions.

Operating costs of community hospitals increased to $90.6 billion in 1981, 101% more than the $45.2 billion in 1976, and 17.9% higher than in 1980.

The American Hospital Association reports that payrolls reached $44.0 billion, representing 48.6% of community hospital expenditures in 1981, the same percentage as 1980. Prior to 1981, payroll as a proportion of expenditures had been steadily decreasing since 1962, when it was 61.9% of expenditures.

Semiprivate Room Charges. A continuing survey conducted by the Health Insurance Association of America shows that as of July 1982, the national average daily cost to the patient for a semiprivate room was $178.49, a 7.5% increase over January 1982. Survey results are based on responses from 2,857 nongovernmental short-term general hospitals nationwide. The highest average rate was in the West, at $207.30 per day. The lowest average rate was in the South, at $140.94 per day.

Professional Fees

Surgical and Dental Charges. Surgical charges vary considerably by geographic region and by metropolitan and nonmetropolitan areas. Table 5.22, containing data from a 1982 survey of insurance company claims conducted by the Health Insurance Association of America, shows the variance of eight common surgical procedures in six major metropolitan and six nonmetropolitan areas.

Results of a 1982 survey of average insurance company dental claims (Table 5.23), show less variation by geographic region.

Physician Fees. As Tables 5.24 and 5.25 show, physician fees vary considerably by type of practice or speciality, type of visit and region of the United States. In 1981, the median charges for an initial office visit and an office revisit were highest for specialists and for physicians practicing in the Western states. In general, the median charges for all non-surgical specialties were higher than for surgical specialities.

Cost of Having a Baby

In 1982, the Health Insurance Association of America conducted a national survey to determine the medical costs incurred in having a baby. As shown in Table 5.26, the average cost for an uncomplicated normal delivery in a delivery room varied from $1,615.80 in the rural West to $2,312.50 in the urban Northeast. The difference in cost is more marked between urban and rural areas than among the four regions of the United States. The cost of a cesarean is considerably higher than a normal delivery—the U.S. average for an uncomplicated cesarean is $3,340.30, compared to $2,092.70 for an uncomplicated normal delivery.

Catastrophic Medical Expenses

A very small percentage of families have catastrophic medical expenses during any given year. A 1982 study by the Congressional Budget Office entitled "Catastrophic Medical Expenses: Patterns in the Non-Elderly, Non-Poor Population" reported on high cost illness among that population. The elderly and poor were not included in the survey because they are generally affected by different health programs. Less than one-fourth of all families in the survey (23%) had medical expenses exceeding $1,130; 11% exceeded $3,000. Only 5% had expenses amounting to more than $5,000, and one-half of 1% had more than $20,000 in medical expenses.

Frequency of Large Health Insurance Claims. A very small proportion of health insurance claims are for very large amounts—those exceeding $25,000. A 1976 survey of large health insurance claims concluded that, of 7,600,000 persons insured under group health insurance contracts, 478 incurred expenses of $25,000 or more—a frequency of 63 per 1,000,000 persons. The average of such large claims was $43,000 per claim. For 1976 expenses of $50,000 or more, the frequency was 15 per 1,000,000. Only nine persons in the study incurred expenses of $100,000 or more. Table 5.27 shows the frequency and average size of large claims by age of insured. Because the data were derived from records of employer-employee group insurance contracts, claims for persons over age 65 were nominal.

Medical Costs Resulting from Accidents

The economic losses that result from various types of accidents are shown in Table 5.28. Medical expense costs incurred through accidents totaled $11.2 billion in 1981.

Table 5.1
National Health Expenditures, 1981 by Type of Expenditure and Source of Funds
(000,000 omitted)

Type of Expenditure	Total	Private*	Public
Personal Health Care	$255.0	$152.1	$102.9
Program Administration and Net Cost of Insurance	11.2	6.9	4.3
Government Public Health Activities	7.3	-	7.3
Research	5.7	0.3	5.3
Construction	7.5	4.8	2.7
Total	$286.6	$164.1	$122.5

NOTE: Details may not add to totals due to rounding.

*Includes spending by philanthropic organizations.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, September 1982.

Table 5.2
Comparison of Growth Rates of Gross National Product and National Health Expenditures

	Gross National Product		National Health Expenditures		
Calendar year	Amount (000,000,000)	Annual rate of growth	Amount (000,000,000)	Annualized percentage change	NHE as percent of GNP
1950	$ 286.5	11.1%	$ 12.7	12.2%	4.4%
1955	400.0	6.9	17.7	7.0	4.4
1960	506.5	4.8	26.9	8.7	5.3
1965	691.0	6.4	41.7	9.2	6.0
1970	992.7	5.2	74.7	13.6	7.5
1971	1,077.6	8.6	83.3	11.5	7.7
1972	1,185.9	10.1	93.5	12.3	7.9
1973	1,326.4	11.8	103.2	10.3	7.8
1974	1,434.2	8.1	116.4	12.8	8.1
1975	1,549.2	8.0	132.7	14.0	8.6
1976	1,718.0	10.9	149.7	12.8	8.7
1977	1,918.0	11.6	169.2	13.1	8.8
1978	2,156.1	12.4	189.3	11.9	8.8
1979	2,413.9	12.0	215.0	13.5	8.9
1980	2,626.1	8.8	249.0	15.8	9.5
1981	2,925.5	11.4	286.6	15.1	9.8

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, September 1982.

Table 5.3
Aggregate and Per Capita Amount and Percentage Distribution of National Health Expenditure by Type of Expenditure, Selected Calendar Years, 1965-1990

Type of expenditure	Historical years					Projected years	
	1965	1970	1975	1980	1981	1985	1990
	Aggregate Amount (in billions)						
Total	$41.7	$74.7	$132.7	$249.0	$286.6	$456.4	$755.6
Health services and supplies	38.2	69.3	124.3	237.1	273.5	438.4	728.9
Personal health care expenses	35.8	65.1	116.8	219.4	255.0	408.2	684.4
Hospital care	13.9	27.8	52.1	100.4	118.0	196.7	340.1
Physicians' services	8.5	14.3	24.9	46.8	54.8	87.9	141.9
Dentists' services	2.8	4.7	8.2	15.4	17.3	26.8	42.3
Other professional services	1.0	1.6	2.6	5.6	6.4	10.1	17.4
Drugs and medical sundries	5.2	8.0	11.9	19.3	21.4	30.2	47.3
Eyeglasses and appliances	1.2	1.9	3.2	5.1	5.7	7.3	11.2
Nursing home care	2.1	4.7	10.1	20.6	24.2	38.9	67.1
Other health services	1.1	2.1	3.7	6.0	7.2	10.3	17.3
Program administration and net cost of insurance	1.6	2.7	4.4	10.7	11.2	20.8	27.8
Government public health activities	.8	1.4	3.2	7.0	7.3	9.4	16.7
Research and medical facilities construction	3.5	5.4	8.4	11.8	13.1	18.0	26.7
Research	1.5	2.0	3.3	5.3	5.7	6.5	9.7
Construction	2.0	3.4	5.1	6.5	7.5	11.5	17.0
	Per Capita Amounts						
Total	$211	$358	$604	$1,075	$1,225	$1,882	$2,982
Health services and supplies	193	332	565	1,024	1,169	1,808	2,877
Personal health care expenses	181	312	531	947	1,090	1,683	2,701
Hospital care	70	133	237	433	504	811	1,342
Physicians' services	43	69	113	202	234	362	560
Dentists' services	14	23	37	67	74	111	167
Other professional services	5	8	12	24	27	42	69
Drugs and medical sundries	26	38	54	83	91	125	187
Eyeglasses and appliances	6	9	14	22	24	30	44
Nursing home care	10	23	46	89	103	160	265
Other health services	6	10	17	26	31	43	68
Program administration and net cost of insurance	8	13	20	46	48	86	110
Government public health activities	4	7	14	30	31	39	66
Research and medical facilities construction	18	26	38	51	56	74	105
Research	8	9	15	23	24	27	38
Construction	10	16	23	28	32	47	67

NOTE: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, March 1983.

Table 5.4
Total Costs of Illness, in Billions of Year-2000 Dollars, and Percentage Distribution of the Costs
(000,000,000 omitted)

Disease category	Total	Direct costs	Indirect Costs		
			Total	Morbidity	Mortality: present value of future earnings discounted at 2.5%
Infective and parasitic diseases	$ 41.1	$ 17.4	$ 23.7	$ 12.0	$ 11.7
Neoplasms	170.8	49.3	121.5	7.6	113.9
Endocrine, nutritional and metabolic diseases	49.2	28.9	20.3	9.2	11.1
Diseases of the blood and blood-forming organs	11.0	6.2	4.8	1.9	2.9
Mental disorders	142.5	85.7	56.8	47.6	9.2
Diseases of the nervous system and sense organs	109.0	61.1	47.9	33.4	14.5
Diseases of the circulatory system	366.1	136.2	229.9	48.3	181.6
Diseases of the respiratory system	155.3	67.0	88.3	57.8	30.5
Diseases of the digestive system, oral cavity, salivary glands and jaws	186.3	125.6	60.7	22.3	38.4
Diseases of the genitourinary system	73.8	51.6	22.2	14.6	7.6
Complications of pregnancy, childbirth and puerperium	34.8	31.9	2.9	2.3	0.6
Diseases of the skin and subcutaneous tissue	23.0	19.2	3.8	3.1	0.7
Diseases of the musculoskeletal system and connective tissue	96.8	48.1	48.7	46.5	2.2
Congenital anomalies and certain causes of perinatal mortality	67.0	4.6	62.4	2.6	59.8
Symptoms and ill-defined conditions	65.3	27.3	38.0	11.1	26.9
Accidents, poisonings and violence	306.3	62.1	244.2	40.4	203.8
Other	62.1	56.7	5.4	5.4	–
Unallocated	135.1	135.1	–	–	–
TOTAL	$2,094.9	$1,013.6	$1,081.3	$366.1	$715.2

NOTE: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Resource Administration, *Public Health Reports*, October 1978.

Table 5.5
National Health Care Expenditures, 1981 by Type of Expenditure and Source of Funds

Type of Expenditure	Total	Private			Public	
		Consumer				
		Direct	In-surance	Other*	Federal	State and Local
	Aggregate Amount (000,000,000 Omitted)					
Total	$286.6	$81.7	$73.2	$9.2	$83.9	$38.6
Health Services and Supplies	273.5	81.7	73.2	4.0	78.4	36.1
Personal Health Care	255.0	81.7	66.8	3.5	74.6	28.3
Hospital Care	118.0	12.8	39.4	1.7	48.7	15.4
Physicians' Services	54.8	20.8	19.0	-	11.6	3.3
Dentists' Services	17.3	12.3	4.3	-	0.4	0.3
Other Professional Services	6.4	3.8	1.1	0.1	1.1	0.3
Drugs and Medical Sundries	21.4	17.1	2.4	-	1.0	0.9
Eyeglasses and Appliances	5.7	4.7	0.3	-	0.6	0.1
Nursing Home Care	24.2	10.3	0.2	0.1	7.5	6.1
Other Health Services	7.2	-	-	1.6	3.8	1.8
Program administration and net cost of insurance	11.2	-	6.4	0.5	2.5	1.8
Government Public Health Activities	7.3	-	-	-	1.3	6.0
Research and Construction of Medical Facilities	13.1	-	-	5.1	5.5	2.6
Research	5.7	-	-	0.3	4.8	0.5
Construction	7.5	-	-	4.8	0.7	2.1
	Per Capita Amount					
Total	$1,225	$349	$313	$39	$359	$165
Health Services and Supplies	1,169	349	313	17	335	154
Personal Health Care	1,090	349	285	15	319	121
Hospital Care	504	54	168	7	208	66
Physicians' Services	234	89	81	-	50	14
Dentists' Services	74	52	19	-	2	1
Other Professional Services	27	16	5	-	5	1
Drugs and Medical Sundries	91	73	10	-	4	4
Eyeglasses and Appliances	24	20	1	-	2	-
Nursing Home Care	103	44	1	1	32	26
Other Health Services	31	-	-	7	16	8
Program administration and net cost of insurance	48	-	27	2	11	8
Government Public Health Activities	31	-	-	-	6	25
Research and Construction of Medical Facilities	56	-	-	22	23	11
Research	24	-	-	1	21	2
Construction	32	-	-	20	3	9

*Spending by philanthropic organizations, industrial in-plant services, and privately financed construction.

Note: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, September 1982.

Table 5.6
Aggregate and Per Capita Personal Health Care Expenditures by Type of Expenditure, by State, 1978
(000,000 omitted)

	Total		Hospital Care		Physicians Services	
	Aggregate	Per Capita	Aggregate	Per Capita	Aggregate	Per Capita
Alabama	$ 2,427.7	$633	$ 1,170.1	$305	$ 481.8	$126
Alaska	294.7	735	147.1	367	56.9	142
Arizona	1,758.2	698	797.6	317	457.8	182
Arkansas	1,311.3	585	537.9	240	270.7	121
California	20,656.5	904	8,473.3	371	5,432.2	238
Colorado	2,005.1	725	856.8	310	425.9	154
Connecticut	2,559.9	827	1,085.4	351	496.0	160
Delaware	431.8	722	204.5	342	87.4	146
District of Columbia	1,135.9	-	747.3	-	208.4	-
Florida	6,996.4	766	2,978.8	326	1,899.0	208
Georgia	3,410.1	645	1,494.9	283	788.7	149
Hawaii	690.8	744	258.0	278	204.1	220
Idaho	504.8	554	179.1	197	123.3	135
Illinois	9,053.8	792	4,602.1	402	1,642.0	144
Indiana	3,655.5	671	1,572.7	289	730.4	134
Iowa	2,112.4	724	896.9	307	386.4	132
Kansas	1,787.6	766	794.0	340	378.6	162
Kentucky	1,958.7	542	874.8	242	376.7	104
Louisiana	2,612.0	641	1,217.5	299	577.1	142
Maine	738.5	662	330.5	296	133.5	120
Maryland	3,133.2	744	1,493.4	355	677.4	161
Massachusetts	5,367.5	935	2,811.3	490	848.1	148
Michigan	7,376.0	802	3,382.6	368	1,661.1	181
Minnesota	2,955.9	738	1,295.9	324	519.8	130
Mississippi	1,383.8	556	626.7	252	274.2	110
Missouri	3,849.3	790	1,904.4	391	803.5	165
Montana	506.0	645	200.4	256	114.7	146
Nebraska	1,151.2	737	505.5	324	254.5	163
Nevada	595.2	828	250.5	348	155.1	216
New Hampshire	540.5	605	228.0	255	118.5	133
New Jersey	5,139.6	699	2,159.7	294	1,200.5	163
New Mexico	709.8	567	350.5	280	144.2	115
New York	15,211.0	858	7,369.2	386	2,801.2	158
North Carolina	3,306.5	576	1,429.5	249	706.2	123
North Dakota	513.2	788	230.2	354	125.2	192
Ohio	7,963.6	738	3,601.7	334	1,828.8	169
Oklahoma	1,934.3	664	824.5	283	411.3	141
Oregon	1,827.1	728	673.6	268	416.7	166
Pennsylvania	8,973.8	756	4,575.8	386	1,620.4	137
Rhode Island	787.1	822	372.9	390	140.3	147
South Carolina	1,584.5	521	686.5	226	313.3	103
South Dakota	459.9	667	203.2	295	81.1	118
Tennessee	3,009.9	675	1,429.5	320	675.2	151
Texas	9,146.1	678	3,923.5	291	2,098.3	155
Utah	757.9	556	308.5	226	182.0	133
Vermont	313.5	630	135.1	271	44.8	90
Virginia	3,316.4	628	1,485.1	281	789.7	149
Washington	2,758.0	710	1,009.0	260	588.1	151
West Virginia	1,173.7	611	610.9	318	237.0	123
Wisconsin	3,434.0	742	1,455.0	314	762.3	165
Wyoming	237.4	551	96.8	225	50.0	116
Total U.S.	$165,517.8	$745	$74,848.7	$337	$35,800.6	$161

NOTE: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, December 1982.

Table 5.7
Factors Affecting Growth of Personal Health Care Expenditures: Twelve Month Period Ending December

	1979	1980	1981
All factors	100%	100%	100%
Prices	72	72	72
Population	8	7	6
Intensity	20	21	22

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, unpublished data.

Table 5.8
Aggregate and Per Capita Amount and Percentage Distribution of Personal Health Care Expenditures, Calendar Year 1981

Source of payment	Aggregate amount (in billions)	Per capita amount	Percentage distribution
Direct payments	$ 81.7	$ 349	32.1%
Third-Party Payments	173.2	740	67.9
Private Health Insurance	66.8	285	26.2
Philanthropy and Industrial In-Plant	3.5	15	1.4
Government	102.9	440	40.1
Federal	74.6	319	29.3
Medicare	43.5	186	17.0
Medicaid	16.4	70	6.4
Other	14.7	63	5.8
State and Local	28.3	121	11.1
Medicaid	13.3	57	4.1
Other	15.0	64	9.0
Total	$255.0	$1,090	100.0%

Note: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, September 1982 and unpublished data.

Table 5.9
Personal Health Care Expenditures by Source of Payment in the United States
(000,000,000 omitted)

Calendar year	Total	Direct payments	Third Party Payments			
			Total	Private health insurance	Govern-ment	Philan-thropy and industry
1966	$ 39.6	$19.5	$ 20.1	$ 9.1	$ 10.1	$0.8
1967	44.4	18.9	25.5	9.6	15.1	0.8
1968	50.2	20.6	29.6	10.9	17.7	0.9
1969	56.9	23.0	33.9	12.9	20.1	0.9
1970	65.1	26.0	39.1	15.6	22.5	1.0
1971	72.0	27.8	44.2	17.3	25.6	1.2
1972	80.2	31.0	49.2	19.1	28.8	1.3
1973	88.7	34.2	54.5	21.1	32.0	1.3
1974	101.0	36.4	64.6	24.5	38.6	1.5
1975	116.8	39.0	77.8	30.1	46.1	1.6
1976	131.8	43.0	88.8	35.5	51.5	1.8
1977	148.7	48.7	100.0	40.0	57.9	2.1
1978	166.7	54.1	112.6	45.0	65.3	2.2
1979	188.9	61.8	127.1	50.2	74.3	2.6
1980	219.4	72.1	147.3	57.0	87.2	3.1
1981	255.0	81.7	173.2	66.8	102.9	3.5

NOTE: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, September 1982.

Table 5.10
Personal Consumption Expenditures by Type of Product in the United States, 1981

Type of Product	Personal consumption expenditures (billions of dollars)	Percent of total
Food (including alcohol)	$ 375.3	20.4%
Housing	295.3	16.0
Transportation	260.8	14.1
Household operation	256.5	13.9
Medical care*	191.1	10.4
Clothing, accessories and jewelry	136.4	7.4
Recreation	117.2	6.4
Personal business	98.6	5.3
Private education and research	29.3	1.6
Religious and welfare activities	25.4	1.4
Personal care	24.6	1.3
Tobacco	23.1	1.3
Foreign travel and remittances-net	4.9	0.3
Death expenses	4.7	0.2
Total	$1,843.2	100.0%

*Includes all expenses for health insurance (except loss of income type).

SOURCES: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, July 1982, and Health Insurance Association of America.

Table 5.11
Ratio of Personal Consumption Expenditures for Medical Care to Disposable Personal Income and to Total Personal Consumption Expenditures in the United States
(000,000,000 omitted)

Calendar year	Personal consumption expenditures for medical care*	Disposable personal income	Total personal consumption expenditures	Ratio of col. (2) to col. (3)	Ratio of col. (2) to col. (4)
(1)	(2)	(3)	(4)	(5)	(6)
1950	$ 8.8	$ 206.6	$ 192.0	4.3%	4.6%
1955	12.8	275.0	253.7	4.7	5.0
1960	19.5	352.0	324.9	5.5	6.0
1965	29.4	475.8	430.4	6.2	6.8
1966	31.8	513.7	465.1	6.2	6.8
1967	34.2	547.9	490.3	6.2	7.0
1968	37.9	593.4	536.9	6.4	7.1
1969	43.7	638.9	581.8	6.8	7.5
1970	49.3	695.3	621.7	7.1	7.9
1971	54.4	751.8	672.2	7.2	8.1
1972	60.6	810.3	737.1	7.5	8.2
1973	67.4	914.5	812.0	7.4	8.3
1974	75.5	998.3	888.1	7.6	8.5
1975	85.4	1,096.1	976.4	7.8	8.7
1976	96.2	1,194.4	1,084.3	8.1	8.9
1977	110.5	1,314.0	1,204.4	8.4	9.2
1978	123.0	1,474.0	1,346.5	8.3	9.1
1979	141.8	1,650.2	1,507.2	8.6	9.4
1980	162.2	1,824.1	1,667.2	8.9	9.7
1981	191.1	2,029.1	1,843.2	9.4	10.4

*Includes all expenses for health insurance (except loss of income type).

SOURCES: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business* (various issues), and Health Insurance Association of America.

Table 5.12
Personal Consumption Expenditures for Medical Care in the United States
(000,000,000 omitted)

Calendar year	Total medical care	Hospital services	Physicians' services	Medicines and appli-ances	Dentists	Net cost of health insurance	All other medical care
1950	$ 8.8	$ 2.0	$ 2.6	$ 2.2	$ 1.0	$0.3	$ 0.7
1955	12.8	3.2	3.5	3.0	1.5	0.6	1.0
1960	19.5	5.3	5.2	4.6	2.0	0.8	1.6
1965	29.4	8.4	8.0	6.2	2.8	1.3	2.8
1966	31.8	9.4	8.5	6.5	2.9	1.4	3.1
1967	34.2	10.7	9.4	6.7	3.2	1.4	2.8
1968	37.9	12.3	10.1	7.5	3.5	1.6	2.8
1969	43.7	15.1	11.5	8.4	4.1	1.9	2.7
1970	49.3	17.6	13.1	9.4	4.6	1.8	2.8
1971	54.4	20.5	14.4	9.9	4.9	2.1	2.6
1972	60.6	22.8	15.7	10.8	5.3	3.2	2.7
1973	67.4	25.4	17.5	11.7	6.3	3.5	3.1
1974	15.5	29.7	19.4	12.8	6.9	3.6	3.2
1975	85.4	34.7	22.5	13.9	7.9	2.8	3.6
1976	96.2	40.4	25.3	15.1	8.9	2.4	4.1
1977	110.5	46.3	29.5	16.4	10.0	3.3	5.1
1978	123.0	52.4	30.9	18.0	12.1	3.3	6.3
1979	141.8	60.1	36.6	20.1	12.9	4.5	7.7
1980	162.2	69.9	42.7	21.7	14.5	4.6	8.9
1981	191.1	84.1	50.4	23.6	17.1	5.9	10.0

NOTE: Data are revised. The data exclude private expenditures in Federal, state, city and other government hospitals and nursing homes. In some cases the sum of the items does not equal the "Total medical care" shown because of rounding.

SOURCE: U.S. Department of Commerce, Bureau of Economic Analysis, *The National Income and Product Accounts of the United States, 1929-76 Statistical Tables* and July 1982 Special Supplement to *Survey of Current Business.*

Table 5.13
Consumer Price Index for Medical Care Items in the United States (1967 = 100.0)

Calendar year	All medical care items	Physicians' fees	Dentists' fees	Hospital room	Drugs and Prescriptions: Prescription drugs	Drugs and Prescriptions: Over the counter items
			Urban wage and clerical workers			
1947	48.1	51.4	56.9	23.1	-	-
1950	53.7	55.2	63.9	30.3	92.6	-
1955	64.8	65.4	73.0	42.3	101.6	-
1960	79.1	77.0	82.1	57.3	115.3	-
1965	89.5	88.3	92.2	75.9	102.0	98.0
1966	93.4	93.4	95.2	83.5	101.8	99.0
1967	100.0	100.0	100.0	100.0	100.0	100.0
1968	106.1	105.6	105.5	113.6	98.3	102.5
1969	113.4	112.9	112.9	128.8	99.6	103.2
1970	120.6	121.4	119.4	145.4	101.2	106.2
1971	128.4	129.8	127.0	163.1	101.3	110.3
1972	132.5	133.8	132.3	173.9	100.9	111.3
1973	137.7	138.2	136.4	182.1	100.5	112.4
1974	150.5	150.9	146.8	201.5	102.9	117.5
1975	168.6	169.4	161.9	236.1	109.3	130.1
1976	184.7	188.5	172.2	268.6	115.2	138.9
1977	202.4	206.0	185.1	299.5	122.1	148.5
1978	219.4	223.3	199.3	331.6	132.1	159.1
			All urban consumers			
1978	219.4	223.1	198.1	332.4	131.6	159.0
1979	239.7	243.6	214.8	370.3	141.8	170.7
1980	265.9	269.3	240.2	418.9	154.8	188.1
1981	294.5	299.0	263.3	481.1	172.5	211.4
1982	328.7	327.1	283.6	556.7	192.7	234.2

NOTE: Beginning January 1978, the Bureau of Labor Statistics introduced a new index for all urban consumers.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, *CPI Detailed Report*.

Table 5.14
Annual Changes in Consumer Price Index

Calendar year	All items	All medical care items	Physicians' fees	Dentists' fees	Hospital room	Drugs and Prescriptions: Prescription drugs	Drugs and Prescriptions: Over the counter items
Urban wage and clerical workers							
1947	14.4%	8.3%	6.4%	8.4%	17.3%	9.9%	–
1950	11.0	1.9	1.5	2.4	3.4	2.7	–
1955	- 0.4	2.2	3.5	1.0	4.2	1.4	–
1960	1.6	3.5	2.5	2.0	6.9	-0.3	–
1965	1.7	2.5	3.6	3.1	5.6	-1.1	0.7%
1966	2.9	4.4	5.8	3.3	10.0	-0.2	1.0
1967	2.9	7.1	7.1	5.0	19.8	-1.8	1.0
1968	4.2	6.1	5.6	5.5	13.6	-1.7	2.5
1969	5.4	6.9	6.9	7.0	13.4	1.3	0.7
1970	5.9	6.3	7.5	5.8	12.9	1.6	2.9
1971	4.3	6.5	6.9	6.4	12.2	0.1	3.9
1972	3.3	3.2	3.1	4.2	6.6	-0.4	0.9
1973	6.2	3.9	3.3	3.1	4.7	-0.4	1.0
1974	11.0	9.3	9.2	7.6	10.7	2.4	4.5
1975	9.1	12.0	12.3	10.3	17.2	6.2	10.7
1976	5.8	9.5	11.3	6.4	13.8	5.4	6.8
1977	6.5	9.6	9.3	7.5	11.5	6.0	6.9
1978	7.6	8.4	8.4	7.7	10.7	8.2	7.1
All urban consumers							
1979	11.3	9.3	9.2	8.4	11.4	7.8	7.4
1980	13.5	10.9	10.6	11.8	13.1	9.2	10.2
1981	10.4	10.8	11.0	9.6	14.8	11.4	12.4
1982	6.1	11.6	9.4	7.7	15.7	11.7	10.8

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, *CPI Detailed Report.*

Table 5.15
Consumer Price Index in the United States (1967 = 100.0)

Calendar year	All items	Food	Apparel	Housing	Transportation	Medical care	Entertainment	Other goods and services
				Urban wage and clerical workers				
1935	41.1	36.5	40.8	49.3	42.6	36.1	41.8	44.6
1940	42.0	35.2	42.8	52.4	42.7	36.8	46.1	48.3
1945	53.9	50.7	61.5	59.1	47.8	42.1	62.4	56.9
1950	72.1	74.5	79.0	72.8	68.2	53.7	74.4	60.9
1955	80.2	81.6	84.1	82.3	77.4	64.8	76.7	79.8
1960	88.7	88.0	89.6	90.2	89.6	79.1	87.3	87.8
1965	94.5	94.4	93.7	94.9	95.9	89.5	95.9	94.2
1966	97.2	99.1	96.1	97.2	97.2	93.4	97.5	97.2
1967	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1968	104.2	103.6	105.4	104.2	103.2	106.1	104.7	104.6
1969	109.8	108.9	111.5	110.8	107.2	113.4	108.7	109.1
1970	116.3	114.9	116.1	118.9	112.7	120.6	113.4	116.0
1971	121.3	118.4	119.8	124.3	118.6	128.4	119.3	120.9
1972	125.3	123.5	122.3	129.2	119.9	132.5	122.8	125.5
1973	133.1	141.4	126.8	135.0	123.8	137.7	125.9	129.0
1974	147.7	161.7	136.2	150.6	137.7	150.5	133.8	137.2
1975	161.2	175.4	142.3	166.8	150.6	168.6	144.4	147.4
1976	170.5	180.8	147.6	177.2	165.5	184.7	151.2	153.3
1977	181.5	192.2	154.2	189.6	177.2	202.4	157.9	159.2
1978	195.3	206.2	159.5	202.6	185.8	219.4	176.2	183.2
				All urban consumers				
1978	195.4	211.4	159.6	202.8	185.5	219.4	176.6	183.3
1979	217.4	234.5	166.6	227.6	212.0	239.7	188.5	196.7
1980	246.8	254.6	178.4	263.3	249.7	265.9	205.3	214.5
1981	272.4	274.6	186.9	293.5	280.0	294.5	221.4	235.7
1982	289.1	285.7	191.8	314.7	291.5	328.7	235.8	259.9

NOTE: Beginning January 1978, the Bureau of Labor Statistics introduced a new index for all urban consumers.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, *CPI Detailed Report.*

Table 5.16
Annual Budget for Urban Family of Four, at Three Levels of Living, Autumn 1981, and Percent Change, Autumn 1980 to Autumn 1981

	Lower		Intermediate		Higher	
	Amount	Change	Amount	Change	Amount	Change
Total Budget	$15,323	9.1%	$25,407	9.8%	$38,060	10.6%
Total Family Consumption	12,069	7.3	18,240	7.5	25,008	7.5
Food	4,545	5.2	5,843	4.9	7,366	4.9
Housing	2,817	8.0	5,546	8.6	8,423	8.7
Transportation	1,311	13.0	2,372	12.1	3,075	11.8
Clothing	937	3.3	1,333	3.2	1,947	3.1
Personal Care	379	7.7	508	7.9	719	7.6
Medical Care	1,436	10.6	1,443	10.7	1,505	10.7
Other	644	7.9	1,196	7.8	1,972	7.8
Other items*	621	6.5	1,021	6.7	1,718	6.7
Taxes and Deductions	2,632	18.7	6,146	18.0	11,333	18.9

*Includes allowances for gifts and contributions, life insurance and occupational expenses.

NOTE: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics.

Table 5.17
Annual Budget for Retired Couple, at Three Levels of Living, Autumn 1981, and Percent Change, Autumn 1980 to Autumn 1981

	Lower		Intermediate		Higher	
	Amount	Change	Amount	Change	Amount	Change
Total Budget	$7,226	8.8%	$10,226	8.4%	$15,078	8.3%
Total Family Consumption	6,914	8.7	9,611	8.4	13,960	8.3
Food	2,183	4.9	2,898	4.5	3,642	4.6
Housing	2,377	9.6	3,393	9.2	5,307	9.2
Transportation	553	13.6	1,073	12.9	1,960	12.1
Clothing	244	3.4	409	3.3	629	3.3
Personal Care	198	7.6	290	7.8	424	7.6
Medical Care	1,085	14.9	1,091	14.8	1,098	14.9
Other	275	7.8	457	7.8	901	7.6
Other items*	311	8.7	615	8.3	1,118	7.8
Taxes and Deductions	–	–	–	–	–	–

*Includes allowances for gifts and contributions, life insurance and occupational expenses.

NOTE: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics.

Table 5.18
Medical Care Component as a Percent of Total Annual Budget

	Four Person Family			Retired Couple		
	Lower	Intermediate	Higher	Lower	Intermediate	Higher
1970	8.1%	5.3%	3.8%	12.3%	8.8%	6.0%
1971	8.4	5.6	4.0	12.7	8.9	5.8
1972	8.5	5.5	4.0	12.6	8.7	5.7
1973	8.1	5.3	3.8	12.0	8.4	5.7
1974	8.0	5.2	3.7	12.6	8.9	6.0
1975	8.5	5.4	3.8	12.2	8.6	5.8
1976	8.9	5.5	4.2	12.2	8.5	5.8
1977	9.4	5.8	4.1	13.3	9.4	6.4
1978	9.2	5.7	4.1	13.9	9.8	6.7
1979	9.3	5.7	4.0	13.9	9.8	6.7
1980	9.2	5.6	3.9	14.2	10.1	6.9
1981	9.4	5.7	4.0	15.0	10.7	7.3

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics.

Table 5.19
Average Cost to Community Hospitals Per Patient Day and Per Patient Stay; Average Length of Stay in Community Hospitals in the United States

Calendar year	Average cost to hospital per patient day			Average length of hospital stay (days)	Average cost to hospital per patient stay
	Total	Payroll	Other		
1946	$ 9.39	$ 4.98	$ 4.41	9.1	$ 85.45
1950	15.62	8.86	6.76	8.1	126.52
1955	23.12	14.26	8.86	7.8	180.34
1960	32.23	20.08	12.15	7.6	244.95
1961	34.98	21.54	13.44	7.6	265.85
1962	36.83	22.79	14.04	7.6	279.91
1963	38.91	24.01	14.90	7.7	299.61
1964	41.58	25.26	16.32	7.7	320.17
1965	44.48	27.44	17.04	7.8	346.94
1966	48.15	29.41	18.74	7.9	380.39
1967	54.08	32.44	21.64	8.3	448.86
1968	61.38	36.61	24.77	8.4	515.59
1969	70.03	41.36	28.67	8.3	581.25
1970	81.01	47.30	33.71	8.2	664.28
1971	92.31	53.80	38.51	8.0	738.48
1972	105.30	59.80	45.50	7.9	831.70
1973	102.40	57.00	45.40	7.8	798.70
1974	113.60	61.90	51.70	7.8	886.10
1975	133.80	70.90	62.90	7.7	1,030.30
1976	151.80	78.00	73.80	7.7	1,168.90
1977	174.00	87.40	86.60	7.6	1,322.40
1978	194.30	96.60	97.70	7.6	1,476.70
1979	217.30	107.30	110.00	7.6	1,651.50
1980	245.10	119.20	125.90	7.6	1,862.80
1981	284.30	138.20	146.10	7.6	2,160.70

NOTE: Data prior to 1972 include hospital units of institutions. Total expenses include: payroll expenses; employee benefits; professional fees; depreciation expense; supplies and purchased services. Payroll expenses include: physicians' and dentists' salaries; medical and dental interns and residents; trainees in medical technology and administration; other personnel. Data for years 1973-1981 have been adjusted to include outpatients.

SOURCES: American Hospital Association, *Hospital Statistics* (various annual editions), and Health Insurance Association of America.

Table 5.20
Community Hospital Statistics—1981

State	Average cost to hospital per day	Average length of hospital stay in days	Average cost to hospital per stay
Alabama	$239.20	7.3	$1,746.20
Alaska	453.00	5.8	2,627.40
Arizona	337.10	6.9	2,326.00
Arkansas	213.70	6.7	1,431.80
California	428.00	6.6	2,824.80
Colorado	292.50	7.0	2,047.50
Connecticut	312.90	7.6	2,378.00
Delaware	260.40	8.3	2,161.30
District of Columbia	430.60	8.6	3,703.20
Florida	287.60	7.5	2,157.00
Georgia	247.30	6.6	1,632.20
Hawaii	276.80	7.9	2,186.70
Idaho	233.60	6.3	1,471.70
Illinois	320.20	8.0	2,561.60
Indiana	246.60	7.7	1,898.80
Iowa	228.20	7.7	1,757.10
Kansas	236.90	7.6	1,800.40
Kentucky	223.40	6.7	1,496.80
Louisiana	289.50	6.4	1,852.80
Maine	248.50	8.0	1,988.00
Maryland	289.90	8.5	2,464.20
Massachusetts	332.80	8.9	2,961.90
Michigan	311.60	7.9	2,461.60
Minnesota	234.50	9.2	2,157.40
Mississippi	202.70	6.9	1,398.60
Missouri	269.90	8.0	2,159.20
Montana	195.30	8.2	1,601.50
Nebraska	219.20	8.6	1,885.10
Nevada	398.40	6.7	2,669.30
New Hampshire	246.70	6.9	1,702.20
New Jersey	239.80	8.6	2,062.30
New Mexico	279.10	6.2	1,730.40
New York	288.80	9.8	2,830.20
North Carolina	222.70	7.5	1,670.30
North Dakota	207.70	8.7	1,807.00
Ohio	281.40	8.0	2,251.20
Oklahoma	279.70	6.4	1,790.10
Oregon	333.90	6.0	2,003.40
Pennsylvania	272.10	8.4	2,285.60
Rhode Island	300.10	8.4	2,520.80
South Carolina	212.40	7.5	1,593.00
South Dakota	194.90	7.9	1,539.70
Tennessee	240.60	7.1	1,708.30
Texas	267.10	6.6	1,762.90
Utah	319.50	5.5	1,757.30
Vermont	213.10	8.2	1,747.40
Virginia	242.20	7.9	1,913.40
Washington	315.00	5.7	1,795.50
West Virginia	228.50	7.4	1,690.90
Wisconsin	251.90	8.3	2,090.80
Wyoming	239.60	6.0	1,437.60
Total U. S.	$284.30	7.6	$2,160.70

SOURCES: American Hospital Association, *Hospital Statistics, 1982*, and Health Insurance Association of America.

Table 5.21
Comparison of Hospital Semiprivate Room Charges by State, January and July 1982 and Percent Change

State	Semiprivate room charge		Percent change
	Jan. 1982	July 1982	Jan. 1982-July 1982
Alabama	$124.29	$134.70	8.4%
Alaska	214.62	232.76	8.5
Arizona	145.95	153.78	5.4
Arkansas	113.26	119.35	5.4
California	215.85	231.19	7.1
Colorado	167.65	179.47	7.1
Connecticut	161.52	162.56	0.6
Delaware	171.63	195.21	13.7
District of Columbia	233.42	243.61	4.4
Florida	139.74	149.02	6.6
Georgia	124.35	133.62	7.5
Hawaii	176.24	192.74	9.4
Idaho	150.76	163.78	8.6
Illinois	191.93	209.12	9.0
Indiana	146.10	152.12	4.1
Iowa	139.12	150.97	8.5
Kansas	140.64	147.79	5.1
Kentucky	127.02	135.76	6.9
Louisiana	115.30	131.29	13.9
Maine	159.97	174.45	9.1
Maryland	148.34	161.59	8.9
Massachusetts	180.50	192.36	6.6
Michigan	185.04	206.32	11.5
Minnesota	145.53	154.10	5.9
Mississippi	91.66	97.16	6.0
Missouri	144.65	154.98	7.1
Montana	150.45	166.98	11.0
Nebraska	134.43	139.31	3.6
Nevada	168.72	188.63	11.8
New Hampshire	167.57	178.73	6.7
New Jersey	171.15	170.14	- 0.6
New Mexico	152.45	164.80	8.1
New York	185.37	198.34	7.0
North Carolina	110.91	117.06	5.5
North Dakota	119.06	132.10	11.0
Ohio	180.61	192.13	6.4
Oklahoma	132.60	142.15	7.2
Oregon	181.43	192.85	6.3
Pennsylvania	186.57	210.81	13.0
Rhode Island	166.49	179.57	7.9
South Carolina	105.42	114.12	8.3
South Dakota	128.96	136.62	5.9
Tennessee	110.96	119.39	7.6
Texas	118.65	128.04	7.9
Utah	146.07	157.30	7.7
Vermont	167.47	178.16	6.4
Virginia	131.93	139.41	5.7
Washington	173.28	183.80	6.1
West Virginia	136.45	142.51	4.4
Wisconsin	146.13	148.01	1.3
Wyoming	133.03	143.66	8.0
Total U. S.	166.08	178.49	7.5

SOURCE: Health Insurance Association of America, *Survey of Hospital Semiprivate Room Charges*, July 1982.

Table 5.22
Average Surgical Charges, Selected Areas of the United States, 1982

Area	Tonsillectomy Adenoidectomy (Under age 18)	Hysterectomy (Total)	Mastectomy (Radical)	Appendectomy	Cholecystectomy	D & C	Vasectomy	Hemorrhoidectomy (External)
Metropolitan								
New York City	$513	$1,942	$2,178	$982	$1,516	$410	$350	$479
Chicago	365	1,236	1,208	649	1,027	336	270	327
Los Angeles	424	1,491	1,611	851	1,148	387	298	267
Dallas	410	1,096	1,295	647	956	308	235	530
Atlanta	318	1,023	1,030	587	795	274	237	404
Philadelphia	321	1,079	1,313	569	835	326	253	340
Nonmetropolitan								
Southern Indiana	277	755	806	442	649	215	198	294
South Eastern Massachusetts	319	788	616	500	755	262	200	250
South Central Pennsylvania	299	826	778	489	718	251	226	273
Kansas (misc.)	263	852	854	449	700	210	229	248
Lousiana (misc.)	314	851	1,033	516	781	268	224	377
Alabama (misc.)	272	750	753	457	722	242	202	334

SOURCE: Health Insurance Association of America (unpublished data).

Table 5.23
Average Dental Charges, Selected Areas of the United States, 1982

Area	Initial oral examination	Prophylaxis—adult	Permanent amalgam filling—two surfaces	Composite resin filling—two surfaces	Porcelain crown with gold	Dentures	
						Complete upper	Complete lower
Metropolitan							
Boston	$13	$21	$27	$31	$371	$330	$310
Milwaukee	9	18	28	30	295	368	355
Washington, D.C.	12	21	32	34	336	392	376
Portland, Oregon	12	25	32	38	280	335	330
New Orleans	11	20	31	32	289	362	354
Cleveland	12	20	30	32	318	346	340
Nonmetropolitan							
Vermont	9	16	24	25	298	288	283
Eastern North Carolina	9	17	25	27	237	228	222
North Michigan (misc.)	12	20	28	32	296	323	310
Nevada (misc.)	13	25	35	36	263	406	376
Texas (misc.)	11	21	34	38	313	354	342
Wyoming	10	20	31	33	254	368	357

SOURCE: Health Insurance Association of America (unpublished data).

Table 5.24
Median Office-Visit Fees by Type of Physician, 1980, 1981 and 1982

	First office visit (usual)			Office revisit (usual)		
	1980	1981	1982	1980	1981	1982
General Practitioners	$20	$21	$21	$15	$16	$17
Family Practitioners	19	21	21	15	16	18
Internists	30	34	36	20	21	22
General Surgeons	21	26	26	16	17	20
OBGs	33	36	40	20	21	23
Pediatricians	21	24	25	16	18	20
All Nonsurgical Specialists	31	35	46	20	21	24
All Surgical Specialists	30	33	40	17	20	21

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Table 5.25
Regional Variations in Median Physician Fees, 1982

Region* and type of visit	General practitioners/ Family practitioners	All surgical specialists	All nonsurgical specialists
East			
Initial visit	$21	$45	$50
Revisit	18	25	25
South			
Initial visit	21	36	46
Revisit	17	21	21
Midwest			
Initial visit	20	35	36
Revisit	17	20	21
West			
Initial visit	26	51	56
Revisit	21	25	26

*East includes New England and Mid-eastern states; South, South Atlantic, Mid-southern and Southwestern states; Midwest, Great Lakes and Plains states; and West, Rocky Mountain and Far Western states.

SOURCE: *Medical Economics Continuing Survey*. Copyright (c) 1981 by Litton Industries, Inc. Published by Medical Economics Company, a Litton division, at Oradell, N.J. 07649. Reprinted by permission.

Table 5.26
Total Medical Costs of Having a Baby

	Usual Delivery		*Cesarean*
	Delivery Room	**Birthing Room**	
Northeast			
Urban	$2,312.50	$2,199.20	$3,708.60
Rural	2,127.10	NA	3,328.50
Total	2,285.50	NA	3,647.50
South			
Urban	1,960.20	1,930.20	3,044.40
Rural	1,810.10	1,782.70	2,916.50
Total	1,912.30	1,889.60	2,986.30
North Central			
Urban	2,287.00	2,137.10	3,620.40
Rural	1,833.80	1,726.80	3,064.90
Total	2,128.40	2,003.80	3,427.20
West			
Urban	2,283.50	2,321.40	3,762.20
Rural	1,615.80	1,503.30	2,860.10
Total	2,148.50	2,170.50	3,584.80
U.S.			
Urban	2,209.10	2,175.90	3,511.80
Rural	1,819.70	1,734.90	3,001.70
Total	2,092.70	2,062.50	3,340.30

NA = Not Available

NOTE: Excludes anesthesiologist's professional fee, which averages $150 nationally for a usual delivery, and pediatrician's newborn care, which averages $64 nationally.

SOURCE: Health Insurance Association of America, Public Relations Division, *The Cost of Having a Baby*.

Table 5.27
Incidence and Average Amounts of Group Health Insurance Claims Exceeding $25,000 (1976 Charges)

	Total	Adults (20-64)	Children (0-19)	Aged (65-99)
Claim Frequency				
Per 1,000,000				
$ 25,000 or more	63.0	72.5	47.3	55.1
50,000 or more	15.4	17.1	12.6	15.8
100,000 or more	1.2	1.3	1.1	0
Average Claim				
$ 25,000 or more	$ 43,000	$ 42,000	$ 45,000	$38,000
50,000 or more	67,000	67,000	69,000	57,000
100,000 or more	120,000	118,000	125,000	-

SOURCE: Health Insurance Association of America, unpublished data.

Table 5.28
Certain Costs of Accidents by Class, 1981
(000,000,000 omitted)

Cost	Total*	Motor vehicle	Work	Home	Public nonmotor vehicle
Total	$87.4	$40.6	$32.5	$9.2	$6.6
Wage loss	23.3	12.5	5.1	3.4	3.5
Medical expense	11.2	3.8	3.4	2.4	1.9
Insurance administration	16.4	9.6	6.6	0.1	0.1
Fire loss	6.7	†	2.3	3.3	1.1
Motor vehicle property damage	14.7	14.7	†	†	†
Indirect work loss	15.1	†	15.1	†	†

*Duplications between work and motor vehicle and home and motor vehicle are eliminated in the totals.

†Not included.

SOURCE: *Accident Facts*, 1982 edition. Copyright (c) 1982 by National Safety Council. Reprinted by permission.

CHAPTER 6
Disability and Health Care Utilization

Disability

Disability rates for both acute and chronic health conditions—as measured by work-loss days, restricted activity days and disability days—vary by social and economic characteristics.

Table 6.1 shows that the higher the educational attainment, the fewer days of disability. Marked differences in the number of disability days are also found in relation to income. The differentials in disability by occupation are not as marked—blue-collar workers averaged 5.9 work-loss days while white-collar workers averaged 4.1 work-loss days.

The disability rates also vary by geographic region. Among the four regions (Northeast, North Central, South and West), persons in the West had the highest level of restricted activity days, 21.5, and the highest frequency of physician visits, 4.9 per person per year. (For definitions, see Table 6.2.)

Persons in the South registered the highest rate of bed-disability, 7.9 per person per year, and the lowest rate of dental visits, 1.5 per person per year.

Acute Conditions. Some 338 million workdays were lost in 1981 as a result of some acute health condition. (For definition, see footnote, Table 6.4.) This was an average of 3.4 days off the job for each worker in the nation.

During 1981, acute illnesses and injuries caused an average of 9.6 days of restricted activity per person and 4.2 bed-disability days per person. A rate of 4.4 school-loss days per child between the ages of 6 and 16 was reported for 1981. The incidence of acute conditions, shown in Table 6.5, decreased somewhat from 1980.

Chronic Conditions. Chronic illness invariably has a long-term impact on people, changing their lifestyles to the extent that they can no longer carry on their major activity, such as working or keeping house, or limiting the kind or duration of their activities. In 1981, 32 million persons, 14.4% of the U.S. civilian noninstitutional population, suffered a limitation of activity because of one or more chronic conditions (Table 6.7). Of that number, some 25 million suffered limitation of their major activity. Males at all ages experienced a higher incidence of activity limitation than females.

Occupational Injuries and Illness. According to the U.S. Department of Labor's latest survey, approximately 5.3 million work-related injuries occurred in 1981, a decrease of 4% from 1980 (Table 6.8). About one injury or illness occurred for every 12 workers in the private economy during 1981.

Some 39.2 million workdays were lost because of work-related injuries in 1981—down from 40.9 million in 1980. The rate per 100 full-time workers decreased from 63.7 lost workdays a year in 1980 to 60.4 in 1981.

About 126,000 reported cases of

occupational illnesses were recorded in 1981 compared with 130,000 in 1980.

Social Security Disability Insurance Program. The Social Security Disability Insurance program is the largest Federal income program for disabled persons. Table 6.9 shows the growth of the Disability Insurance program from 1965 to 1982. The number of recipients (both the number of workers, and the number of workers and dependents) was greatest in 1978, and has decreased each year since.

Trends in Utilization Of Services

Hospital Utilization. Approximately one of six Americans (based on the civilian noninstitutional population) was admitted to a community hospital in 1981. Community hospitals, defined as nonfederal, short-term, general and special hospitals providing general medical care to the public, account for 84% of all hospitals and handle 93% of all admissions.

An average of 99,800 persons entered community hospitals each day in 1981—36,438,232 admissions over the 12-month period. This was a 20.9% increase over 1971.

On an average day in 1981, there were 763,101 patients in community hospitals, or 3.4 per 1,000 population. This rate has remained constant since 1974.

The nation's community hospitals treated 202.8 million outpatient cases in 1981. This was a 0.2% increase over 1980 and 36.6% over 1971.

A National Center for Health Statistics survey of short-stay hospital utilization in 1980 reported the average length of stay was 7.7 days for males and 7.0 days for females. Females, however, had a higher rate of hospitalization than males, 196.6 per 1,000 compared to 140.7 per 1,000 for men. Length of stay increased with age from 4.6 days for children under 15, to 10.5 days for persons aged 65 and over. The Northeast registered the longest average length of stay, 8.5 days for all ages, while the Western region had the shortest, 6.0 days.

Physician and Dental Visits. According to estimates of the U.S. Department of Health and Human Services' *Health Interview Survey,* Americans made 1,039 million visits to physicians in 1981. The average number of visits per person was 4.6. (For definition, see Table 6.14.)

The survey also showed that Americans made 380 million visits to dentists in 1981. The average number of visits per person was 1.7. (For definition, see Table 6.14.) Fifty percent of the population had last visited a dentist within a year.

A government survey of ambulatory patient visits in 1980 (where there was contact with a physician) showed that the largest proportion of office visits, 33%, were made to general and family practitioners. About 36% of visits were due to acute conditions, 37% to chronic conditions and 27% were post-surgery, post-injury or non-illness related. Visits to solo practitioners outnumbered those to physicians in multiple-member practices 55% to 45%. The proportion of visits to physicians' offices in metropolitan areas exceeded the proportion in nonmetropolitan areas by about three to one.

Office visits per year increased in direct proportion to advancing age.

About 60% of all office visits by adults were made by women.

Diseases of the respiratory system accounted for 13% of all visits and another 9% of visits were for diseases of the circulatory system.

The following eight diagnostic groups accounted for about 75% of the principal diagnoses made by physicians in office practice.

	Percent
Special conditions and examinations without illness	17.8
Diseases of the respiratory system	12.7
Diseases of the circulatory system	9.3
Diseases of the nervous system and sense organs	9.1
Injuries and poisonings	8.0
Diseases of the genitourinary system	5.7
Diseases of the musculoskeletal system and connective tissue	6.4
Diseases of the skin and subcutaneous tissue	6.3

Table 6.1
Disability Due to Chronic and Acute Conditions, by Social and Economic Characteristics in the United States, 1981
(Days per person)

Characteristics	Restricted activity	Bed disability	Work-loss
Sex			
Both Sexes	19.1	6.9	4.9
Male	17.3	5.8	4.6
Female	20.7	7.9	5.3
Family Income			
Under $ 3,000	31.4	11.2	5.4
$ 3,000 - 4,999	38.8	14.7	6.4
5,000 - 6,999	30.7	10.3	6.5
7,000 - 9,999	26.2	9.5	6.1
10,000 - 14,999	18.4	6.4	5.5
15,000 - 24,999	15.5	5.5	5.2
25,000 and over	13.1	4.7	4.2
Educational Attainment			
Under 9 Years	41.9	14.5	7.3
9 - 11 Years	24.9	8.9	7.0
12 Years	18.3	6.0	4.8
13 - 15 Years	17.9	6.1	4.6
16 Years and over	14.2	4.9	3.1
Occupation			
White Collar	12.1	3.9	4.1
Professional, Technical & Kindred	12.1	3.7	3.5
Managers & Administrators (except farm)	11.2	3.5	3.5
Clerical & Kindred	12.7	4.5	5.1
Sales	12.6	3.9	3.9
Blue Collar	13.1	3.8	5.9
Craftsmen & Kindred	12.6	3.6	5.3
Operatives & Kindred	14.3	4.2	7.0
Laborers (except farm)	11.1	3.1	4.3
Service	15.7	5.7	6.4
Farm	8.2	2.1	3.1

NOTE: The data refer to the civilian, noninstitutional population. A "Restricted activity day" is one on which a person cuts down on his usual activities for the whole of that day because of an illness or injury. A "Bed disability day" is one on which a person stays in bed for all or most of the day because of a specific illness or injury. A "Work-loss day" is a day on which a currently employed person, 17 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. "Family Income" includes the total income of each member of the family. "Educational Attainment" refers to the number of years of schooling the individual has received.

SOURCE: National Center for Health Statistics, U.S. Department of Health and Human Services, *Current Estimates From the Health Interview Survey: United States — 1981*.

Table 6.2
Selected Health Characteristics by Geographic Region in the United States, 1981
(Days/visits per person)

Characteristics	Total	Geographic Region			
		Northeast	North Central	South	West
Restricted activity days*	19.1	18.1	17.1	20.0	21.5
Days of bed disability*	6.9	6.7	6.0	7.9	6.7
Work-loss days*	4.9	4.9	4.9	5.1	4.6
Physician visits	4.6	4.7	4.5	4.5	4.9
Dental visits	1.7	2.0	1.7	1.5	1.7

*Chronic and acute conditions.

NOTE: The data refer to the civilian, noninstitutional population. A "Restricted activity day" is one on which a person cuts down on his usual activities for the whole of that day because of an illness or injury. A "Bed disability day" is one on which a person stays in bed for all or most of the day because of a specific illness or injury. A "Work-loss day" is a day on which a currently employed person, 17 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. A "Physician visit" is a consultation with a physician, in person or by telephone, for examination, diagnosis, treatment or advice. A "Dental visit" is any visit to a dentist's office for treatment or advice.

SOURCE: National Center for Health Statistics, U.S. Department of Health and Human Services, unpublished data.

Table 6.3
Days of Disability Per Person Per Year, By Type of Disability Day: United States, 1979-1981 (Chronic and Acute Conditions)

Type of Disability Day	Days of Disability per person per year		
	1979	1980	1981
Restricted activity days	19.0	19.1	19.1
Bed disability days	6.7	7.0	6.9
Work-loss days (ages 17 years and over)	5.0	5.0	4.9
School-loss days (ages 6-16 years)	5.3	5.3	4.9

NOTE: The data refer to the civilian, noninstitutional population. A "Restricted activity day" is one on which a person cuts down on his usual activities for the whole of that day because of an illness or injury. A "Bed disability day" is one on which a person stays in bed for all or most of the day because of a specific illness or injury. A "Work-loss day" is a day on which a currently employed person, 17 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. A "Physician visit" is a consultation with a physician, in person or by telephone, for examination, diagnosis, treatment or advice. A "Dental visit" is any visit to a dentist's office for treatment or advice. A school-loss day is a normal school day on which a child age 6-16 did not attend school because of a specific illness or injury.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the Health Interview Survey: United States — 1981.*

Table 6.4
Workdays Lost Due to Acute Conditions In the United States, 1981

Acute Conditions	Number of work-loss days (000,000)			Work-loss days per employed person		
	All ages 17 and over	Age 17-44	Age 45 and over	All ages 17 and over	Ages 17-44	Age 45 and over
Both Sexes						
All acute conditions	338	247	91	3.4	3.6	3.0
Infective and parasitic diseases	27	22	5	0.3	0.3	0.2
Respiratory conditions	141	98	43	1.4	1.4	1.4
Digestive system conditions	17	14	*	0.2	0.2	*
Injuries	97	71	26	1.0	1.0	0.8
All other acute conditions	56	42	14	0.6	0.6	0.5
Male						
All acute conditions	171	123	48	3.0	3.2	2.6
Infective and parasitic diseases	12	9	*	0.2	0.2	*
Respiratory conditions	75	51	24	1.3	1.3	1.3
Digestive system conditions	9	7	*	0.1	0.2	*
Injuries	57	44	13	1.0	1.1	0.7
All other acute conditions	19	12	7	0.3	0.3	0.4
Female						
All acute conditions	167	124	43	3.9	4.1	3.5
Infective and parasitic diseases	15	13	*	0.3	0.4	*
Respiratory conditions	67	48	19	1.6	1.6	1.5
Digestive system conditions	8	7	*	0.2	0.2	*
Injuries	40	27	13	0.9	0.9	1.1
All other acute conditions	38	30	8	0.9	1.0	0.6

*Figures do not meet standards of reliability or precision.

NOTE: The data refer to the civilian, noninstitutional population. An acute condition is one which lasted less than 3 months and which involved either medical attention or restricted activity. A "Work-loss day" is a day on which a currently employed person, 17 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. In some cases the sum of the items does not equal the total shown, because of rounding.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the Health Interview Survey: United States — 1981.*

Table 6.5
Incidence of Acute Conditions, Associated Disability Days and Persons Injured — United States, 1979-1981

Item	1979	1980	1981
Acute Conditions	**Number of acute conditions per 100 persons per year**		
All acute conditions	215.3	222.2	212.4
Infective and parasitic diseases	24.4	24.6	23.6
Respiratory conditions	107.3	116.2	111.9
Upper respiratory conditions	60.1	57.0	55.7
Influenza	40.5	52.0	49.7
Other respiratory conditions	6.7	7.0	6.5
Digestive system conditions	11.4	11.4	9.7
Injuries	34.5	33.4	33.2
All other acute conditions	37.7	36.6	34.1
Days of Disability Associated with Acute Conditions	**Days of disability per 100 persons per year**		
Restricted-activity days	939.9	986.9	959.1
Bed-disability days	413.4	426.6	419.0
Work-loss days (ages 17 years and over)	350.6	347.7	337.4
School-loss days (ages 6-16 years)	477.8	487.2	436.2
Class of Accident	**Number of persons injured per 100 persons per year**		
All classes of accidents	32.0	31.2	31.2
Moving motor vehicle	2.3	2.0	2.2
While at work	5.6	5.0	5.0
Home	11.5	12.2	12.0
Other	14.0	12.9	13.2

NOTE: The data refer to the civilian, noninstitutional population. An acute condition is one which lasted less than 3 months and which involved either medical attention or restricted activity. A "Work-loss day" is a day on which a currently employed person, 17 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. In some cases the sum of the items does not equal the total shown, because of rounding. Details may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the Health Interview Survey: United States — 1981*.

Table 6.6
Days Lost from School Per 100 Children (6-16 years) Per Year, Due to Acute Conditions, by Sex and Condition Group: United States, 1981

Condition Group	Both sexes	Male	Female
All acute conditions	436.2	396.3	478.2
Infective and parasitic diseases	83.9	69.4	99.1
Respiratory conditions	253.2	237.5	269.6
Upper respiratory conditions	114.1	103.7	125.0
Influenza	119.5	121.6	117.3
Other respiratory conditions	19.5	*	27.3
Digestive system conditions	20.0	18.1	21.9
Injuries	36.5	39.5	33.3
All other acute conditions	42.7	31.7	54.3

NOTE: Details may not add to totals due to rounding.

*Figures do not meet standards of reliability or precision.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the Health Interview Survey: United States — 1981.*

Table 6.7
Percent Distribution of Persons with Limitation Of Activity Due to Chronic Conditions, By Degree of Limitation According to Sex and Age: 1981

(Civilian noninstitutional population)

Sex and age	Total population	With activity limitation	With limitation in major activity	With no activity limitation
		Percent distribution		
Both sexes				
All ages	100.0%	14.4%	10.9%	85.6%
Under 17 years	100.0	3.8	2.0	96.2
17 - 44 years	100.0	8.4	5.4	91.6
45 - 64 years	100.0	23.9	19.1	76.1
65 years and over	100.0	45.7	39.2	54.3
Male				
All ages	100.0	14.6	11.3	85.4
Under 17 years	100.0	4.4	2.4	95.6
17 - 44 years	100.0	8.9	5.7	91.1
45 - 64 years	100.0	24.9	20.5	75.1
65 years and over	100.0	49.6	44.7	50.4
Female				
All ages	100.0	14.2	10.6	85.8
Under 17 years	100.0	3.1	1.5	96.9
17 - 44 years	100.0	7.9	5.1	92.1
45 - 64 years	100.0	23.1	17.9	76.9
65 years and over	100.0	43.1	35.3	56.9

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the Health Interview Survey: United States — 1981.*

Table 6.8
Number of Occupational Injuries and Illnesses, And Lost Workdays, Private Sector, by Industry Division, in the United States, 1981

Industry	Total cases* (000)	Lost workday cases (000)	Total lost workdays (000)	Average lost workdays per lost workday case
Injuries and Illness				
Private sector†	5,404	2,458	40,051	16
Agriculture, forestry and fishing†	90	44	607	14
Mining	134	72	1,684	23
Construction	538	225	4,019	18
Manufacturing	2,209	977	15,750	16
Transportation and public utilities	439	255	4,882	19
Wholesale and retail trade	1,191	511	7,432	15
Wholesale trade	388	180	2,754	15
Retail trade	803	331	4,679	14
Finance, insurance and real estate	90	38	544	14
Services	714	336	5,132	15
Injuries				
Private sector†	5,278	2,409	39,199	16
Agriculture, forestry and fishing†	86	42	597	14
Mining	132	71	1,676	24
Construction	530	222	3,985	18
Manufacturing	2,139	951	15,257	16
Transportation and public utilities	432	252	4,851	19
Wholesale and retail trade	1,178	505	7,330	15
Wholesale trade	382	177	2,693	15
Retail trade	796	328	4,637	14
Finance, insurance and real estate	89	38	533	14
Services	693	328	4,970	15
Illnesses				
Private sector†	126	49	852	18
Agriculture, forestry and fishing†	4	1	10	9
Mining	2	1	8	12
Construction	8	3	34	13
Manufacturing	70	27	493	19
Transportation and public utilities	7	3	30	11
Wholesale and retail trade	13	5	102	19
Wholesale trade	5	2	61	25
Retail trade	7	3	41	13
Finance, insurance and real estate	2	1	12	16
Services	22	9	162	19

*Includes fatalities. † Excludes farms with fewer than 11 employees.

NOTE: Because of rounding, the sum of the components may not add to the totals. Differences between the estimate of total cases and the estimates for lost workday cases and nonfatal cases without lost workdays may not reflect the fatality estimate.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics.

Table 6.9
Growth in the Social Security Disability Insurance Program, 1965-81

Year	Number of workers insured for disability (000,000 omitted)	Disabled workers receiving benefits		Total disability insurance beneficiaries (000 omitted)	Total cash benefits paid for disability (000,000,000 omitted)
		Number (000 omitted)	Number per 100,000 insured workers		
1965	53.3	988.1	1,854	1,739.1	$ 1.6
1966	55.0	1,097.2	1,995	1,970.3	1.8
1967	55.7	1,193.1	2.142	2,140.2	1.9
1968	56.9	1,295.3	2,276	2,335.1	2.3
1969	70.1	3,394.3	1,989	2,487.5	2.5
1970	72.4	1,492.9	2,062	2,665.0	3.1
1971	74.5	1,647.7	2,212	2,930.0	3.8
1972	76.1	1,832.9	2,409	3,271.5	4.5
1973	77.8	2,016.6	2,592	3,559.0	5.7
1974	80.4	2,236.9	2,782	3,911.3	6.9
1975	83.3	2,488.8	2,988	4,352.2	8.4
1976	85.3	2,670.2	3,130	4,623.8	10.0
1977	87.0	2,837.4	3,261	4,860.4	11.5
1978	89.4	2,879.8	3,221	4,868.5	12.5
1979	93.8	2,870.4	3,060	4,777.4	13.7
1980	95.6*	2,861.3	2,993	4,682.2	15.4
1981	96.8*	2,776.5	2,868*	4,456.3	17.2*
1982	NA	2,723.0*	NA	4,374.0	NA

*Preliminary estimates.

SOURCES: U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin*, August 1982, and U.S. Senate, Committee on Finance, *Staff Data and Materials Related to the Social Security Disability Insurance Program, 1982*.

Table 6.10
Utilization of Community Hospitals in the United States
(Per 1,000 Population)

Year	Beds	Average daily census	Admissions
1950	3.4	2.5	111.4
1955	3.5	2.5	117.3
1960	3.6	2.7	129.2
1965	3.9	3.0	138.8
1970	4.2	3.3	145.6
1971	4.3	3.3	148.2
1972	4.3	3.2	150.0
1973	4.3	3.3	153.2
1974	4.4	3.4	157.8
1975	4.5	3.4	159.2
1976	4.5	3.4	160.5
1977	4.6	3.4	161.4
1978	4.6	3.4	161.1
1979	4.6	3.4	162.4
1980	4.5	3.4	165.8
1981	4.5	3.4	161.9

NOTE: Data refer to the civilian noninstitutional population.

SOURCES: American Hospital Association, *Hospital Statistics* (various annual editions), and Health Insurance Association of America.

Table 6.11
Rate of Discharges and Average Length of Stay for Patients Discharged from Short-Stay Non-Federal Hospitals, by Sex: United States, 1980

All Listed Diagnostic Categories*	Rate of discharges per 1,000 population*			Average length of stay (days)		
	Total	Male	Female	Total	Male	Female
All conditions	169.6	140.7	196.6	7.3	7.7	7.0
All Ischemic Heart Disease	20.0	22.8	17.5	9.6	9.2	10.1
Malignant Neoplasms and Carcinoma-In-Situ	13.2	13.4	13.1	12.0	12.0	12.0
Benign Neoplasms and Neoplasms of uncertain behavior	5.4	2.9	7.8	6.2	5.7	6.3
Fractures, all sites	7.6	8.2	6.9	10.8	9.0	12.6
Diseases of the Urinary System	5.6	5.5	5.7	5.9	5.7	6.1
Pneumonia, all forms	5.4	6.0	4.9	8.3	8.2	8.4
Chronic Disease of Tonsils and Adenoids	2.6	2.3	2.8	1.9	1.8	1.9
Cerebrovascular Disease	7.7	7.2	8.1	12.7	12.1	13.2
Diabetes Mellitus	10.2	8.4	12.0	10.5	10.1	10.7
Inguinal Hernia	2.7	5.0	0.5	4.7	4.7	5.0
Choleithiasis	3.2	1.8	4.4	9.3	9.9	9.1
Appendicitis	1.0	1.2	0.9	5.5	5.8	5.5
Childbirth	–	–	71.3†	–	–	3.8
With complications	–	–	1.5†	–	–	38.6
Without complications	–	–	69.7†	–	–	3.0

*Based on number of "all listed" diagnoses, to include all incidences of condition. This results in higher rates of discharge than data for previous years.

†Rate of discharge for childbirth is based on population of women aged 15-44.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, unpublished data.

Table 6.12
Rate of All Listed Surgical Operations for Patients Discharged from Non-Federal Short-Stay Hospitals, by Age and Sex: United States, 1980

Age	Rate per 1,000 Population		
	Both sexes	Male	Female
Total	109.8	79.0	169.1
Under 15 years	35.9	40.8	30.8
15-44 years	121.2	57.4	182.3
45-64 years	122.8	110.4	134.0
65 years and over	193.2	222.7	172.7

NOTE: Rates are based on surgical operations excluding biopsies and diagnostic procedures.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, unpublished data.

Table 6.13
Selected Community Hospital Facilities, Services and Special Beds in the United States, 1981

Selected facility or service	Percent of community hospitals
Emergency Department	93.9%
Postoperative Recovery Room	92.8
Rehabilitation Outpatient	33.6
Family Planning Services	8.8
Open-Heart Surgery Facilities	10.4
X-Ray Therapy	20.3
Megavoltage Therapy	16.3
Radioactive Implants	23.4
Organ Bank	3.5
Blood Bank	76.5
Respiratory Therapy	92.5
Premature Nursery	31.3
Speech Pathology Services	43.4
Hemodialysis:	
Inpatient	24.4
Outpatient	12.8
Genetic Counseling Services	7.1
Physical Therapy	88.1
Occupational Therapy	36.3
Psychiatric Partial Hospitalization Program	10.8
Psychiatric Outpatient Services	13.8
Alcoholism/Chemical Dependency Outpatient Services	12.3
Home Care Department	11.4
Hospice	7.9

SOURCE: American Hospital Association, *Hospital Statistics, 1982.*

Table 6.14
Number of Physician and Dental Visits Per Person In the United States, 1981

Type of visit	All ages	Under 17 years	17-24 years	25-44 years	45-64 years	65 years and over
Physician Visits						
Both Sexes	4.6	4.1	4.0	4.4	5.1	6.3
Male	4.0	4.3	2.6	3.2	4.7	6.0
Female	5.2	4.0	5.4	5.5	5.4	6.6
Dental Visits						
Both Sexes	1.7	1.6	1.6	1.8	1.8	1.5
Male	1.5	1.5	1.4	1.5	1.8	1.4
Female	1.8	1.7	1.8	2.0	1.8	1.5

NOTE: The data refer to the civilian, noninstitutional population. A "Physician Visit" is a consultation with a physician, in person or by telephone, for examination, diagnosis, treatment or advice. A "Dental Visit" is any visit to a dentist's office for treatment or advice.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the Health Interview Survey: United States — 1981.*

CHAPTER 7
Health Manpower

According to the Department of Labor, some 5.0 million persons were active in the health field in 1981.

Physicians

According to the American Medical Association's latest available figures, there were 435,545 active physicians in the United States and possessions at year-end 1980, including 17,787 physicians employed by the Federal government. Some 91.1% of all active non-Federal physicians were involved in direct care of their patients while the remainder were engaged in administration, research, teaching and other activities. Of those in patient care, 75.0% had office-based practices and 25.0% had hospital-based practices. Some 11.2% of physicians were women.

According to Table 7.3, in 1980 the District of Columbia had the highest ratio of non-Federal physicians to population, followed by Massachusetts, Maryland, New York and Connecticut. The lowest ratios of physicians to population occurred in Mississippi, Idaho, South Dakota and Wyoming.

Dentists

In 1978, the number of active dentists in the United States reached an estimated 117,223, including 6,214 dentists employed by the Federal government. According to the latest available data (Table 7.3), the District of Columbia, Washington, Connecticut, New York and Oregon had the highest ratios of dentists to population, while Mississippi, Arkansas, Alabama and West Virginia had the lowest. Table 7.1 shows that 60% of the dental work force in 1981 comprised auxiliary personnel (dental hygienists, assistants and laboratory technicians).

Nurses

Between 1965 and 1982, the number of registered nurses employed in nursing doubled to reach an estimated 1,204,200. The data, while excluding inactive nurses, include those employed in nursing on a part-time basis.

A survey by the American Nurses Association in 1980 concluded that almost 3% of all registered nurses were male, compared with less than 1% in 1966. The number of licensed practical nurses has also increased in recent years.

In 1982, there were an estimated 578,900 licensed practical nurses employed in nursing. Licensed practical nurses provide personal care to patients, including most of the personal care given to elderly patients in long-term care institutions.

Pharmacists

In 1981, there were 152,000 licensed pharmacists in the United States. In 1978-79 (the latest years for which data are available), 16.4% of pharmacists were women.

About 72% of active pharmacists practiced privately in community phar-

macies, and 20% practiced full- or part-time in hospitals. Other pharmacists were employed by manufacturers, taught or were engaged in other pharmaceutical activities such as research.

Table 7.1
Estimated Number of Persons Active In Selected Health Occupations, 1981

Occupation	Number of Persons Active
Clinical Laboratory Technician	276,000
Dentistry and Allied Services	
Dentist	130,000
Dental Hygienist	55,000
Dental Assistant	143,000
Dietician	63,000
Nursing and Related Services	
Registered Nurse	1,339,000
Practical Nurse	403,000
Nursing Aide, Orderly, Attendant	1,131,000
Pharmacist	152,000
Physician (includes Doctor of Medicine and Doctor of Osteopathy	454,000
Psychologist	117,000
Radiologic Technician	104,000
Therapist (includes occupational, physical, respiratory, speech)	251,000

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, unpublished data.

Table 7.2
Estimated Active Health Professionals in the United States
(50 States and District of Columbia)

Year	Total Number			Per 100,000 Population*		
	Physicians	Dentists	Nurses	Physicians	Dentists	Nurses
1965	277,575	97,000	613,000	143	50	317
1970	302,203	102,500	722,000	148	50	356
1971	322,228	N.A.	750,000	156	N.A.	366
1972	333,259	105,500	780,000	160	51	376
1973	338,111	N.A.	815,000	161	N.A.	390
1974	350,609	N.A.	857,000	166	N.A.	407
1975	366,425	N.A.	906,000	172	N.A.	427
1976	373,557	111,178	961,000	174	52	449
1977	377,468	N.A.	981,500†	174	N.A.	455
1978	396,445	117,223	1,028,400†	182	54	473
1979	412,216	N.A.	1,074,500†	184	N.A.	490
1980	430,621	N.A.	1,119,100†	190	N.A.	506
1981	N.A.	N.A.	1,163,800†	N.A.	N.A.	520
1982	N.A.	N.A.	1,204,200†	N.A.	N.A.	533

N.A. — Not available.

*Resident population of 50 states and District of Columbia.

†Preliminary estimate.

NOTE: Data are revised from previous editions and include Federally-employed professionals in the 50 states and the District of Columbia. "Physicians" refers to all active physicians. "Dentists" refers to all active dentists. "Nurses" refers to registered nurses employed in nursing.

SOURCES: American Medical Association; U.S. Department of Health and Human Services, Bureau of Health Professions, Division of Health Professions Analysis. Interagency on Nursing Statistics. *Nurse Supply, Distribution and Requirements—3rd Report to the Congress, February 17, 1982;* American Nurses' Association; and U.S. Department of Commerce, Bureau of the Census, Current Population Reports, P-25, #905.

Table 7.3
Number and Rate per 100,000 Population of Active Physicians, Pharmacists and Dentists, by State

State	Non-Federal Physicians 1980		Pharmacists*		Dentists 1979	
	Number	Rate**	Number	Rate†	Number	Rate†
Alabama	4,856	125	2,495	67	1,314	35
Alaska	491	129	232	56	232	57
Arizona	4,814	178	2,189	92	1,173	48
Arkansas	2,772	121	1,686	78	714	33
California	54,082	230	14,631	66	14,052	62
Colorado	5,664	198	2,414	89	1,701	61
Connecticut	7,730	249	2,605	84	2,194	70
Delaware	949	161	375	64	265	46
District of Columbia	3,474	552	731	109	587	89
Florida	17,479	179	6,856	79	4,323	49
Georgia	7,728	143	3,956	78	2,167	42
Hawaii	1,885	207	400	44	599	65
Idaho	1,007	107	716	81	459	51
Illinois	20,885	183	8,002	71	5,999	53
Indiana	7,022	128	3,891	72	2,234	41
Iowa	3,657	126	2,265	78	1,396	48
Kansas	3,668	157	1,581	67	1,080	46
Kentucky	4,820	133	2,393	69	1,490	42
Louisiana	6,501	155	3,108	78	1,586	39
Maine	1,680	150	647	59	489	45
Maryland	11,210	268	3,236	78	2,591	62
Massachusetts	15,564	272	5,144	89	3,983	69
Michigan	14,626	158	6,861	75	4,772	52
Minnesota	7,718	189	2,939	73	2,429	60
Mississippi	2,664	107	1,697	70	763	31
Missouri	7,979	163	3,708	76	2,303	47
Montana	1,040	133	699	90	442	56
Nebraska	2,319	149	1,472	94	931	59
Nevada	1,097	138	493	74	340	48
New Hampshire	1,490	162	571	66	465	52
New Jersey	13,937	190	5,800	79	4,706	64
New Mexico	1,972	153	875	72	511	41
New York	46,808	267	13,435	76	12,611	71
North Carolina	8,874	153	3,269	59	2,175	39
North Dakota	884	137	604	92	312	47
Ohio	17,458	162	6,501	61	5,064	47
Oklahoma	3,850	128	2,464	87	1,192	41
Oregon	4,760	181	1,988	81	1,685	67
Pennsylvania	22,098	186	8,943	76	6,272	53
Rhode Island	1,988	211	857	92	509	55
South Carolina	4,129	135	2,054	71	1,130	39
South Dakota	766	112	611	89	286	42
Tennessee	7,169	157	3,214	74	2,034	46
Texas	21,531	152	9,380	72	5,757	43
Utah	2,373	162	1,003	76	853	62
Vermont	1,087	212	307	63	270	55
Virginia	9,154	175	3,177	61	2,599	50
Washington	7,381	180	3,141	83	2,611	67
West Virginia	2,610	134	1,082	58	703	37
Wisconsin	7,462	158	3,224	69	2,654	56
Wyoming	530	113	396	93	216	48
Total United States	413,692	183	160,318	73	117,223	53
Puerto Rico	3,887	N.A.	60	N.A.	588	N.A.
U.S. Territories and Possessions	179	N.A.	46	N.A.	42	N.A.
Grand Total	417,758	N.A.	160,424	74	117,853	N.A.

N.A. — Not available.
*Data concerning pharmacists were collected during 1978 and 1979.
**Rates based on civilian population as of 7/1/80.
†Rates based on resident population as of 7/1/79.
NOTE: "Physicians" and "Dentists" refer to all active physicians and dentists. "Pharmacists" refers to all licensed pharmacists.
SOURCES: American Medical Association, *Physician Distribution and Medical Licensure in the U.S., 1980*; American Dental Association, *Distribution of Dentists in the United States, by State, Region, District, and County, 1979*; and U.S. Department of Health and Human Services, National Center for Health Statistics, unpublished data.

Appendix I

Historic Dates

1798 U.S. Marine Hospital Service established by U.S. Congress. Compulsory deductions for hospital service were made from seamen's wages.

1847 The first insurer to issue sickness insurance was organized: The Massachusetts Health Insurance Company of Boston.

1849 New York State passed the first general insurance law.

1850s The first insurance supervisory boards were created in New Hampshire, Massachusetts, Rhode Island and Vermont.

1850 Individual accident insurance became available in the United States with the chartering of the Franklin Health Assurance Company in Massachusetts.

1851 One of the earliest voluntary mutual protection associations, *La Societe Francaise de Bienfaisance Mutuelle,* was organized in San Francisco. It is noteworthy for having established a hospital in 1852 to provide care for its members.

1855 The first separate insurance department, independent of any established agency, was created in Massachusetts.

1859 The first full-time insurance commissioner was appointed in New York.

1863 The Travelers Insurance Company of Hartford, Connecticut, offered accident insurance for railway mishaps; then all forms of accident protection. It was the first company to issue insurance on a basis resembling its present form.

1875 A number of mutual benefit associations, called "establishment funds," were formed for employees of a single employer. The benefits provided usually included small payments for death and disability.

1890 Policies providing benefits for disability from specified diseases were first offered.

1890s This period brought the promotion of many fraternal associations, assessment mutuals and industrial insurers. Because many of these companies and associations were inadequately financed and poorly managed, many states passed legislation against them.

1900 Shortly after the turn of the century, disability benefits became available for substantially all diseases.

1910 Montgomery Ward & Co., Inc. replaced its "employee establishment fund" with an insured contract. This plan is generally regarded as the first group health insurance policy.

1912 The Standard Provisions Law drafted by the National Convention of Insurance Commissioners (now the NAIC) was enacted by most states. This model law sought to provide uniformity and fairness in the "operating conditions" of the health insurance contract.

1916 First non-cancellable disability income contract was offered.

1917 Group accidental death and dismemberment insurance was first written.

1920s Early in this decade individual hospitals began offering hospital expense benefits on an individual prepaid basis.

1920s First partial disability benefits for sickness and accident became available.

1929 The first health maintenance organization, the Ross-Loos Clinic, was established in Los Angeles, California.

1929 A group of school teachers arranged for Baylor Hospital in Dallas, Texas to provide room and board and specified ancillary services at a predetermined monthly cost. This plan is considered the forerunner of what later became known as the Blue Cross plans.

1929 With the depression, many companies entered a period of retrenchment in their disability income product line, particularly in the area of maintaining reasonable indemnity limits in order to avoid overinsurance.

1930s The depression stimulated the expansion of insurance coverages through both public demand and hospitals' encouragement.

1932 First citywide Blue Cross plan was tried out with a group of hospitals in Sacramento, California.

1935 The Social Security Act (P.L. 74-241) provided for the first time grant-in-aid to states for such public health activities as maternal and child care, aid to crippled children, blind persons, the aged and other health-impaired persons.

1937 Health Service Plan Commission (Blue Cross Commission) was organized.

1938 Hospital insurance for dependents of covered persons was developed.

1938 Private insurers introduced group surgical expense benefit plans.

1939 The first Blue Shield plan (surgical-medical), called the California Physicians' Service, was developed.

1940s During World War II, as a result of the freezing of wages, group health insurance became an important component of collective bargaining for employee benefits.

1942 Compulsory cash sickness benefits were begun by four states (Rhode Island, 1942; California, 1946; New Jersey, 1948; New York, 1949).

1943 Private insurers introduced group medical expense benefits (Physician's Visits Expense Benefits).

1946 The Health Insurance Council, a federation of eight insurance associations organized to give technical and practical assistance on health insurance to the providers of medical care, was formed.

1946 Blue Shield Medical Care Plans, Inc. (Blue Shield Commission) was organized.

1948 The National Labor Relations Board ruled, in a dispute between the United Steelworkers' Union and the Inland Steel Company, that the term

"wages" be construed to include pension and insurance benefits. The U.S. Supreme Court upheld this ruling in a 1949 decision.

1949 Major medical expense benefits were introduced by Liberty Mutual Insurance Company to supplement basic medical care expenses.

1954 Congress introduced the disability "freeze" that stated that the quarters during which a worker is disabled are not counted in determining the number of quarters needed to be fully or currently insured under Old Age and Survivors Insurance (OASI).

1956 Disability insurance was added to the Social Security System, providing monthly cash benefits for insured persons who are totally disabled.

1957 Vision care expense benefits were introduced by private insurers, followed in 1959 by extended care facility expense benefits.

1959 Continental Casualty Company issued the first comprehensive group dental insurance plan written by an insurance company.

1960s First disability contracts for business use appeared (overhead expense, keyman).

1960s Eligibility for disability benefits under Social Security was expanded.

1961 First state enrollment plan was made available by Connecticut to persons 65 and over on a state basis and under special enabling legislation allowing the pooling of risks by a group of insurance companies (Associated Connecticut Health Insurance Companies).

1963 The Health Professions Educational Assistance Act (P.L. 88-129) aided training of physicians, dentists and other public health personnel.

1964 Prescription drug expense benefits were introduced.

1964 The Nurse Training Act (P.L. 88-581) provided special Federal effort for training professional nursing personnel.

1965 Social Security Amendments of 1965 (P.L. 89-97) established a Social Security hospital insurance program for the aged and voluntary supplementary medical insurance program (Medicare) and grants to states for medical assistance programs (Medicaid).

1966 Program of governmental health insurance, Medicare, for people aged 65 and over, became effective July 1.

1967 The Age Discrimination in Employment Act (ADEA) became effective.

- The Act applied only to employees between the ages of 40 and 65, and the vast majority of employee benefit plans provided them with the same benefits as younger employees.
- The Act contained a specific provision (Section 4(f)(2)) which stated that it was permissible for an employer to observe the terms of any bona fide employee benefit plan such as a retirement, pension or insurance plan which was not a subterfuge

to evade the purposes of the Act.

1971 The Insurance Medical Scientist Scholarship Fund was formed by several insurance companies, providing full scholarships for students planning careers in medical research and teaching.

1972 Social Security Amendments of 1972 (P.L. 92-603) extended health insurance benefits (Medicare) to the disabled and to end-stage renal disease patients; established Professional Standards Review Organization (PSRO) programs; expanded research and demonstrations of financing mechanisms; and introduced automatic cost of living adjustments to disability benefits.

1972 Legislation created the Supplemental Security Income program, which federalized categorical public assistance for the aged, blind, and permanently and totally disabled.

1973 The Health Maintenance Organization Act (P.L. 93-222) assisted in the establishment and expansion of HMOs.

1974 Employee Retirement Income Security Act (ERISA) of 1974 signed into law. While generally thought of as a law that regulates private pension plans, the Act also contains provisions relating to other employee benefit plans that have encouraged the growth of self-insurance.

1975 The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) authorized major Federal reorganization of health planning programs and set up the national designation of local Health Systems Areas and governing agencies.

1976 The Health Professions Educational Assistance Act of 1976 (P.L. 94-484) contained provisions requiring medical school students who receive Federal scholarship aid to serve a specified period in rural and inner city areas, and required that medical schools with teaching hospitals provide for a greater proportion of medical residencies in primary medicine.

1976 The Health Maintenance Organization Amendments of 1976 (P.L. 94-460) relaxed requirements for HMOs to qualify for Federal support.

1976 The National Consumer Health Information and Health Promotion Act of 1976 (P.L. 94-317) set forth national goals for health information and promotion and a systematic strategy for their achievement, stressing health education.

1977 The Medicare-Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142) amended the Social Security Act to require uniform reporting of financial data by providers; upgraded criminal penalties for fraud under Medicare-Medicaid programs; and amended certain Professional Standards Review Organization (PSRO) provisions.

1978 The Health Maintenance Organization Amendments of 1978 (P.L. 95-559) set forth a three-year extension of the HMO assistance program.

1978 Title VII of the Civil Rights Act of 1964 was amended to prohibit sex discrimination on the basis of pregnancy for all employment-related purposes.

1978 ADEA of 1967 was amended to raise the mandatory retirement age from 65 to 70. The Act prohibits discrimination concerning benefits to older workers. An employer may coordinate benefits with other programs—e.g., Medicare for employees over age 65—provided that total benefits are equivalent to those offered younger workers.

1981 The Omnibus Budget Reconciliation Act mandated significant cuts in Federal expenditures for health programs; increased Medicare deductibles; removed limit on number of states that can apply for Medicare and Medicaid cost reimbursement waivers; and directed the Secretary of HHS to develop a model prospective reimbursement methodology for inpatient services under Medicare and Medicaid.

1982 Tax Equity and Fiscal Responsibility Act of 1982 provided Medicare recognition for any state hospital cost control system that meets certain Federal standards, including equitable treatment of all payors; for employees age 65-69 with employer-sponsored health insurance, made Medicare secondary payor; brought Federal employees under Medicare; and made certain changes in the methods of hospital reimbursements under Medicare.

Appendix II

Adjustments for Duplication in Number Of Persons Under Age 65 Covered, 1981

(000 omitted)

Type of insurer	Number of People under Age 65 Covered				
	Hospital expense	Surgical expense	Physician's expense	Major medical expense	Dental expense
Insurance Companies					
Group Insurance (Regular Business)	70,042	70,202	65,657	83,645	36,761
ASO & MPP Business	31,366	33,398	29,771	30,879	31,875
Total Group Insurance	101,408	103,600	95,428	114,524	68,636
Individual Hospital Medical Expense Coverage	12,661	11,023	9,786	6,446	–
Hospital Indemnity	7,753	–	–	–	–
Total Individual Insurance	20,414	11,023	9,786	6,446	–
Deduction for Duplication of Persons with Insurance Company Protection	20,625	15,254	13,922	14,854	7,550
Net Total for Insurance Companies	101,197	99,369	91,292	106,116	61,086
Blue Cross/Blue Shield	76,343†	63,315†	60,108†	47,391†	12,487††
Other Plans	35,932†	41,332†	40,092†	31,175†	35,531††
Consumers (Prepaid)	10,780†	14,466†	12,028†	10,911†	14,212††
Labor Management (self-funded)	25,152†	26,866†	28,064†	20,264†	21,319††
Deduction for Duplication of Persons Protected by More than One Type of Insurer	40,746	38,378	38,173	30,169	22,802
Net Total All Insurers	172,726	165,638	153,319	154,513	86,302

†Estimate. ††All ages.

SOURCE: Health Insurance Association of America.

Appendix III

Adjustments for Duplication in Number Of Persons Age 65 and Over Covered, 1981

(000 omitted)

Type of insurer	Number of People Age 65 and Over Covered				
	Hospital expense	Surgical expense	Physician's expense	Major medical expense	Dental expense
Insurance Companies					
Group Insurance (Regular Business)	2,645	1,283	1,283	876	-
ASO & MPP Business	1,346	598	598	458	-
Total Group Insurance	3,991	1,881	1,881	1,334	-
Individual Hospital Medical Expense Coverage	2,396	1,402	1,402	187	-
Hospital Indemnity	2,782	-	-	-	-
Total Individual Insurance	5,178	1,402	1,402	187	-
Deduction for Duplication of Persons with Insurance Company Protection	1,994	628	628	202	-
Net Total for Insurance Companies	7,175	2,655	2,655	1,319	-
Blue Cross/Blue Shield†	9,430	8,456	8,028	1,000	-
Other Plans†	4,373	3,511	3,230	2,542	-
Consumers (Prepaid)†	1,312	1,229	969	890	-
Labor Management (self-funded)†	3,061	2,282	2,261	1,652	-
Deduction for Duplication of Persons Protected by More than One Type of Insurer	5,364	3,362	3,288	1,672	-
Net Total All Insurers	15,614	11,260	10,625	3,189	-

†Estimate.

SOURCE: Health Insurance Association of America.

Glossary

Accident an event or occurrence which is unforeseen and unintended.

Accidental Bodily Injury injury to the body as the result of an accident.

Accumulation Period a specified period of time, such as 90 days, during which the insured person must incur eligible medical expenses at least equal to the deductible amount in order to establish a benefit period under a major medical expense or comprehensive medical expense policy.

Actuary a person professionally trained to apply probability and statistics to the practical problems of insurance and related fields. He/she may specialize in life insurance, health insurance (long-term disability and medical), property and casualty insurance, pension work, government programs or a combination of these. His/her responsibilities include calculation of premiums, policy values, reserves and dividends, preparation of statistical studies and forecasting of financial results. Because of his/her broad training an actuary often has administrative and executive responsibilities.

Administrative Services Only (ASO) Plan an arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group.

Adverse Selection the tendency of persons with poorer than average health expectations to apply for, or continue, insurance to a greater extent than do persons with average or better health expectations.

Age Limits stipulated minimum and maximum ages below and above which the company will not accept applications or may not renew policies.

Agent an insurance company representative licensed by the state who solicits, negotiates, or effects contracts of insurance, and provides service to the policyholder for the insurer.

Aggregate Indemnity the maximum dollar amount that may be collected for any disability, period of disability, or under the policy.

Allocated Benefits benefits for which the maximum amount payable for specific services is itemized in the contract.

Amendment a formal document changing the provisions of an insurance policy signed jointly by the insurance company officer and the policyholder or his authorized representative.

Application a signed statement of facts requested by the company on the basis of which the company decides whether or not to issue a policy. This then becomes part of the health insurance contract when the policy is issued.

Approval (1) word used in connection with the filing of policy and certificate forms and rates with the state insurance department. (2) a word used in connection with the underwriting process of an insurance company and consists of the acceptance of the risk as set forth in the application as made or modified by the insurer. (3) acceptance of an offer from an applicant or policyholder in the form of a contract for new insurance, reinstatement of a terminated policy, request for a policy loan, etc., by an officer of the company.

Assignment the signed transfer of benefits of a policy by the owner of the policy to a third party.

Association Group a group formed from members of a trade or a professional association for group insurance under one master health insurance contract.

Beneficiary the person designated or provided for by the policy terms to receive the proceeds upon the death of the insured.

Benefits the amount payable by the insurance company to a claimant, assignee, or beneficiary under each coverage.

Binding Receipt a receipt given for a premium payment accompanying the application for insurance. If the policy is approved, this binds the company to make the policy effective from the date of the receipt.

Blanket Contract a contract of health insurance affording benefits, such as accidental death and dismemberment, for all of a class of persons not individually identified. It is used for such groups as athletic teams, campers, travel policy for employees, etc.

Blanket Medical Expense a provision which entitles the insured person to collect up to a maximum established in the policy for all hospital and medical expenses incurred, without any limitations on individual types of medical expenses.

Blue Cross an independent, nonprofit membership corporation providing protection on a service basis against the cost of hospital care in a limited geographical area.

Blue Shield an independent, nonprofit membership corporation providing protection on a service basis against the cost of surgical and medical care in a limited geographical area.

Broker an insurance solicitor, licensed by the state, who places business with a variety of insurance companies. A broker represents the buyer of insurance rather than the companies; he is paid commissions by the companies.

Business Insurance a policy which primarily provides coverage of benefits to a business as contrasted to an individual. It is issued to indemnify a business for the loss of services of a key employee or a partner who becomes disabled.

Certificate of Insurance a statement of coverage issued to an individual insured under a group insurance contract, outlining the insurance benefits and principal provisions applicable to the member.

Claim a demand to the insurer for the payment of benefits under the insurance contract.

Coinsurance a policy provision frequently found in major medical insurance, by which both the insured person and the insurer share the covered losses under a policy in a specified ratio, i.e., 80% by the insurer and 20% by the insured.

Comprehensive Major Medical Insurance a policy designed to give the protection offered by both a basic and a major medical health insurance policy. It is characterized by a low deductible amount, a coinsurance feature and high maximum benefits.

Consideration one of the elements for a binding contract. Consideration is acceptance by the insurance company of the payment of the premium and the statement made by the prospective policyholder in the application.

Contributory a group insurance plan issued to an employer under which both the employer and employee contribute to the cost of the plan. Seventy-five percent of the eligible employees must be insured. (see Noncontributory)

Conversion Privilege a privilege granted in an insurance policy to convert to a different plan of insurance without providing evidence of insurability. The privilege granted by a group policy is to convert to an individual policy upon termination of group coverage.

Coordination of Benefits (COB) the specific term used to designate the anti-duplication provision designed by the group health insurance industry through the Health Insurance Association of America (HIAA) to limit benefits for multiple group health insurance in a particular case to 100% of the expenses covered and to designate the order in which the multiple carriers are to pay benefits.

Covered Expenses hospital, medical, and miscellaneous health care expenses incurred by the insured that entitle him to a payment of benefits under a health insurance policy. Found most often in connection with major medical plans, the term defines, by either description, reasonableness, or necessity to specify the type and amount of expense which will be considered in the calculation of benefits.

Deductible the amount of covered charges incurred by the protected person which must be assumed or paid by the insured before benefits by the insurance company become payable. A deductible is most commonly used in major medical policies; however, it may also be incorporated in base plan policies.

Disability physical or mental handicap resulting from sickness or injury. It may be partial or total. (see Partial Disability; Total Disability)

Disability Income Insurance a form of health insurance that provides periodic payments to replace income when an insured person is unable to work as a result of illness, injury or disease.

Dismemberment loss of body members (limbs), or use thereof, or loss of sight due to injury.

Double Indemnity a policy provision usually associated with death, which doubles payment of a designated benefit when certain kinds of accidents occur.

Dread Disease Insurance insurance providing an unallocated benefit, subject to a maximum amount, for expenses incurred in connection with the treatment of specified diseases, such as cancer, poliomyelitis, encephalitis and spinal meningitis.

Duplication of Benefits overlapping or identical coverage of the same insured under two or more health plans, usually the result of contracts of different insurance companies, service organizations, or pre-payment plans; also known as multiple coverage.

Earned Premium that portion of a policy's premium payment for which the protection of the policy has already been given. For example, an insurance company is considered to have earned 75% of an annual premium after a period of nine months of an annual term has elapsed.

Effective Date the date on which the insurance under a policy begins.

Eligibility Date the date on which an individual member of a specified group becomes eligible to apply for insurance under the [group life or health] insurance plan.

Eligibility Period a specified length of time, frequently 31 days, following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence of insurability.

Eligible Employees those members of a group who have met the eligibility requirements under a group life or health insurance plan.

Elimination Period a period of time between the period of disability and the start of disability income insurance benefits, during which no benefits are payable. (see Waiting Period)

Enrollment Card a document signed by an employee as notice of his/her desire to participate in the benefits of a group insurance plan.

Evidence of Insurability any statement of proof of a person's physical condition and/or other factual information affecting his/her acceptance for insurance.

Exclusions specific conditions or circumstances listed in the policy for which the policy will not provide benefit payments.

Experience a term used to describe the relationship, usually expressed as a percent or ratio, of premium to claims for a plan, coverage, or benefits for a stated time period.

Experience Rating the process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience.

Experience Refund a provision in most group policies for the return of premium to the policyholder because of lower than anticipated claims.

Family Expense Policy a policy which insures both the policyholder and his/her immediate dependents (usually spouse and children).

Flat Schedule a type of schedule in group insurance under which everyone is insured for the same benefits regardless of salary, position, or other circumstances.

Franchise Insurance a form of insurance in which individual policies are issued to the employees of a common employer or the members of an association under an arrangement by which the employer or association agrees to collect the premiums and remit them to the insurer.

Fraternal Insurance a cooperative type of insurance provided by social organizations for their members.

Geographic Divisions (in the United States)

NORTHEAST

New England: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Middle Atlantic: New Jersey, New York, Pennsylvania

NORTH CENTRAL

East North Central: Illinois, Indiana, Michigan, Ohio, Wisconsin

West North Central: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota

SOUTH

South Atlantic: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia

East South Central: Alabama, Kentucky, Mississippi, Tennessee

West South Central: Arkansas, Louisiana, Oklahoma, Texas

WEST

Mountain: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

Pacific: Alaska, California, Hawaii, Oregon, Washington.

Grace Period a specified period after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

Group Contract a contract of insurance made with an employer or other entity that covers a group of persons identified as individuals by reference to their relationship to the entity.

Guaranteed Renewable Contract a contract that the insured person or entity has the right to continue in force by the timely payment of premiums for a substantial period of time, during which period the insurer has no right to make unilaterally any change in any provision of the contract, while the contract is in force, other than a change in the premium rate for classes of policyholders.

Health Insurance protection which provides payment of benefits for covered sickness or injury. Included under this heading are various types of insurance such as accident insurance, disability income insurance, medical expense insurance, and accidental death and dismemberment insurance.

Health Maintenance Organization (HMO) an organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment. The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital-medical plans.

Hospital Expense Insurance health insurance protection against the cost of hospital care resulting from the illness or injury of the insured person.

Hospital Indemnity a form of health insurance which provides a stipulated daily, weekly or monthly indemnity during hospital confinement. The indemnity is payable on an unallocated basis without regard to the actual expense of hospital confinement.

Hospital Medical Insurance a term used to indicate protection which provides benefits for the cost of any or all of the numerous health care services normally covered under various health care plans.

Incontestable Clause an optional clause which may be used in noncancellable or guaranteed renewable health insurance contracts providing that the insurer may not contest the validity of the contract after it has been in force for two (sometimes three) years.

Indemnity benefits paid in a predetermined amount in the event of a covered loss.

Individual Insurance policies which provide protection to the policyholder and/or his/her family. Sometimes called Personal Insurance as distinct from group and blanket insurance.

Injury Independent of All Other Means an injury resulting from an accident, provided that the accident was not caused by an illness.

Insurable Risk the conditions that make a risk insurable are: (a) the peril insured against must produce a definite loss not under the control of the insured, (b) there must be a large number of homogeneous exposures subject to the same perils, (c) the loss must be calculable and the cost of insuring it must be economically feasible, (d) the peril must be unlikely to affect all insureds simultaneously, (e) the loss produced by a risk must be definite and have a potential to be financially serious.

Insurance protection by written contract against the financial hazards (in whole or in part) of the happenings of specified fortuitous events.

Insurance Company any corporation primarily engaged in the business of furnishing insurance protection to the public.

Insuring Clause the clause which sets forth the type of loss being covered by the policy and the parties to the insurance contract.

Integration a coordination of the disability income insurance benefit with other disability income benefits, such as Social Security, through a specific formula to insure reasonable income replacement.

Key-Man or Key-Person Health Insurance an individual or group insurance policy designed to protect a firm against the loss of income resulting from disability of a key employee.

Lapse termination of a policy upon the policyholder's failure to pay the premium within the time required.

Legal Reserve the minimum reserve which a company must keep to meet future claims and obligations as they are calculated under the state insurance code.

Level Premium a premium which remains unchanged throughout the life of a policy.

Lifetime Disability Benefit a benefit to help replace income lost by an insured person as long as he/she is totally disabled, even for a lifetime.

Limited Policy a contract which covers only certain specified diseases or accidents.

Long-Term Disability Income Insurance insurance issued to an employer (group) or individual to provide a reasonable replacement of a portion of an employee's earned income lost through serious and prolonged illness or injury during the normal work career. (See also Integration)

Major Medical Insurance health insurance to finance the expense of major illness and injury. Characterized by large benefit maximums ranging up to $250,000 or no limit, the insurance, above an initial deductible, reimburses the major part of all charges for hospital, doctor, private nurses, medical appliances, prescribed out of hospital treatment, drugs and medicines. The insured person as co-insurer pays the remainder.

Manual Rate the premium rate developed for a group insurance coverage from the company's standard rate tables normally referred to as its rate manual or underwriting manual.

Medicaid state programs of public assistance to persons regardless of age whose income and resources are insufficient to pay for health care. Title XIX of the Federal Social Security Act provides matching Federal funds for financing state Medicaid programs, effective January 1, 1966.

Medicare the hospital insurance system and the supplementary medical insurance for the aged created by the 1965 amendments to the Social Security Act and operated under the provisions of the Act.

Minimum Group the least number of employees permitted under a state law to effect a group for insurance purposes; the purpose is to maintain some sort of proper division between individual policy insurance and the group forms.

Minimum Premium Plan an arrangement under which an insurance carrier will, for a fee, handle the administration of claims and insure against large claims for a self-insured group.

Miscellaneous Expenses expenses in connection with hospital insurance, hospital charges other than room and board, such as X-rays, drugs, laboratory fees and other ancillary charges. (Sometimes referred to as Ancillary Charges.)

Morbidity the incidence and severity of sicknesses and accidents in a well defined class or classes of persons.

Multiple Employer Trust (MET) a legal trust established by a plan sponsor that brings together a number of small, unrelated employers for the purpose of providing group medical coverage on an insured or self-funded basis.

Mutual Insurance Company an insurance company which has no stockholders. It is managed by a board of directors, elected by its policyholders. Any earnings in excess of those necessary for the operation of the company are returned to the policyholders in the form of dividends. (see Stock Insurance Company)

National Association of Insurance Commissioners (NAIC) the association of insurance commissioners of various states formed to promote national uniformity in the regulation of insurance.

Noncancellable Guaranteed Renewable Policy an individual policy which the insured person has the right to continue in force until a specified age, such as to age 65, by the timely payment of premiums. During this period, the insurer has no right to unilaterally make any changes in any provision of the policy while it is in force.

Noncontributory a term applied to employee benefit plans under which the employer bears the full cost of the benefits for the employees. One hundred percent of the eligible employees must be insured.

Nondisabling Injury an injury which may require medical care, but does not result in loss of working time or income.

Nonoccupational Policy contract which insures a person against off-the-job accident or sickness. It does not cover disability resulting from injury or sickness covered by Worker's Compensation. Group Accident and Sickness policies are frequently nonoccupational.

Nonparticipating Insurance plan of insurance under which the policyholder is not entitled to share in the dividend distribution of the company.

Nonprofit Insurers persons organized under special state laws to provide hospital, medical or dental insurance on a nonprofit basis. The laws exempt them from certain types of taxes.

Occupational Hazards occupations which expose the insured to greater than normal physical dangers by the very nature of the work in which the insured is engaged, and the varying periods of absence from the occupation, due to the disability, that can be expected.

Optionally Renewable Contract a contract of health insurance in which the insurer reserves the right to terminate the coverage at any anniversary or, in some cases, at any premium due date, but does not have the right to terminate coverage between such dates.

Overhead Insurance a type of short-term disability income contract that reimburses the insured person for specified, fixed, monthly expenses, normal and customary in the operation and conduct of his/her business or office.

Partial Disability the result of an illness or injury which prevents an insured from performing one or more of the functions of his/her regular job.

Participating Insurance insurance issued by an insurance company providing participation in dividend distribution.

Physician's Expense Insurance coverage which provides benefits toward the cost of such services as doctor's fees for nonsurgical care in the hospital, at home or in a physician's office, and X-rays or laboratory tests performed outside the hospital. (Also called Regular Medical Expense Insurance.)

Policy the legal document issued by the company to the policyholder which outlines the conditions and terms of the insurance; also called the policy contract or the contract.

Policy Term that period for which an insurance policy provides coverage.

Pre-Existing Condition a physical and/or mental condition of an insured which first manifested itself prior to the issuance of his/her policy or which existed prior to issuance and for which treatment was received.

Preferred Provider Organization (PPO) an arrangement whereby a third party payor contracts with a group of medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients.

Premium the periodic payment required to keep a policy in force.

Pre-Paid Group Practice Plan a plan under which specified health services are rendered by participating physicians to an enrolled group of persons, with a fixed periodic payment in advance made by or on behalf of each person or family. If a health insurance carrier is involved, a contract to pay in advance for the full range of health services to which the insured is entitled under the terms of the health insurance contract. Such a plan is one form of Health Maintenance Organization (HMO).

Principal Sum the amount payable in one sum in the event of accidental death and in some cases accidental dismemberment.

Professional Standards Review Organization (PSRO) an organization in which practicing physicians assume responsibility for reviewing the propriety and quality of health care services provided under Medicare and Medicaid.

Proration the adjustment of benefits paid because of a mistake in the amount of the premiums paid or the existence of other insurance covering the same accident or disability.

Qualified Impairment Insurance a form of substandard or special class insurance which restricts benefits for the insured person's particular condition.

Reasonable and Customary Charge a charge for health care, which is consistent with the going rate or charge in a certain geographical area for identical or similar services.

Recurring Clause a provision in some health insurance policies which specifies a period of time during which the recurrence of a condition is considered a continuation of a prior period of disability or hospital confinement.

Rehabilitation (1) restoration of a totally disabled person to a meaningful occupation, (2) a provision in some long-term disability policies that provides for continuation of benefits or other financial assistance while a totally disabled insured is retraining or attempting to resume productive employment.

Reinstatement the resumption of coverage under a policy which has lapsed.

Reinsurance the acceptance by one or more insurers, called reinsurers, of a portion of the risk underwritten by another insurer who has contracted for the entire coverage.

Renewal continuance of coverage under a policy beyond its original term by the insurer's acceptance of the premium for a new policy term.

Residual Disability Benefits a provision in an insurance policy that provides benefits in proportion to a reduction of earnings as a result of disability, as opposed to the inability to work full-time.

Rider a document which amends the policy or certificate. It may increase or decrease benefits, waive the condition of coverage, or in any other way amend the original contract.

Risk any chance of loss.

Self-Administration the procedure where an employer maintains all records regarding the employees covered under a group insurance plan.

Self-Insurance a program for providing group insurance with benefits financed entirely through the internal means of the policyholder, in place of purchasing coverage from commercial carriers.

Senior Citizen Policies contracts insuring persons 65 years of age or over. In most cases these policies supplement the coverage afforded by the government under the Medicare program.

Short-Term Disability Income Insurance the provision to pay benefits to a covered disabled person as long as he/she remains disabled up to a specified period not exceeding two years.

Social Security Freeze a long-term disability policy provision which establishes that the offset from benefits paid by Social Security will not be changed regardless of subsequent changes in the Social Security law.

Special Risk Insurance coverage for risks or hazards of a special or unusual nature.

Standard Insurance insurance written on the basis of regular morbidity underwriting assumption used by an insurance company and issued at normal rates.

Standard Provision those contract provisions generally required by state statutes until superseded by the uniform policy provision.

Standard Risk a person who, according to a company's underwriting standards, is entitled to insurance protection without extra rating or special restrictions.

State Disability Plan a plan for accident and sickness, or disability insurance required by state legislation of those employers doing business in that particular state.

State Insurance Department a department of a state government whose duty is to regulate the business of insurance and give the public information on insurance.

Stock Insurance Company an insurance company owned and controlled by its stockholders, who share in the surplus earnings. (see Mutual Insurance Company)

Substandard Insurance insurance issued with an extra premium or special restriction to those persons who do not qualify for insurance at standard rates.

Substandard Risk an individual, who, because of health history or physical limitations, does not measure up to the qualification of a standard risk.

Surgical Expense Insurance health insurance policies which provide benefits towards the physician's or surgeon's operating fees. Benefits may consist of scheduled amounts for each surgical procedure.

Surgical Schedule a list of cash allowances attached to the policy, which are payable for various types of surgery, with a maximum amount based upon the severity of the operation.

Third Party Administration administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

Time Limit the period of time during which a notice of claim or proof of loss must be filed.

Total Disability an illness or injury which prevents an insured person from continuously performing every duty pertaining to his/her occupation or engaging in any other type of work. (This wording varies among insurance companies.)

Travel Accident Policy a limited contract covering only accidents while an insured person is traveling, usually on a commercial carrier.

Unallocated Benefit a policy provision providing reimbursement up to a maximum amount for the cost of all extra miscellaneous hospital services, but not specifying how much will be paid for each type of service.

Underwriter the term as generally used applies to either (a) a company which receives the premiums and accepts responsibility for the fulfillment of the policy contract; (b) the company employee who decides whether or not the company should assume a particular risk; (c) the agent who sells the policy.

Underwriting the process by which an insurer determines whether or not and on what basis an application for insurance will be accepted.

Unearned Premium that portion of the paid premium applying to the unexpired portion of the policy term; or that portion of the paid premium for which protection has not been received.

Uninsurable Risk one not acceptable for insurance due to excessive risk.

Waiting Period the length of time an employee must wait from his/her date of employment or application for coverage, to the date his/her insurance is effective. (see Probationary Period)

Waiver an agreement attached to a policy which exempts from coverage certain disabilities or injuries which are normally covered by the policy.

Waiver of Premium a provision included in some policies which exempts the policyholder from paying the premiums while an insured is totally disabled, during the life of the contract.

Worker's Compensation insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured, and to pay benefits to dependents of employees killed in the course of or arising out of their employment.

Written Premiums the entire amount of premiums due in a year for all policies issued by an insurance company.

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